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Building the Foundation of a Mentoring Program for Chief Nurse Executives

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Abstract

The chief nurse executive (CNE) is the senior leader whose primary responsibility is to assure quality of care and patient experience in acute care hospitals. Uncertainty in the political arena and further changes to the Affordable Care Act (ACA) highlight the need for hospitals to maintain continuity of leadership for the executive closest to patient care – the CNE. In a large and complex health system, the role of the CNE can be an overwhelming responsibility for seasoned professionals – and especially daunting if you are new to the role of CNE or new to an organization as an experienced CNE.

The Patient Care Services (PCS) division of a large hospital system/health management organization with a region in northern California has addressed succession planning to ensure there are viable candidates for vacated CNE positions throughout the region. Two programs were launched to assist high-potential nurse leaders advance to the role of CNE – the Nurse Executive Accelerated Leadership Development Program (NEALDP) and the Nurse Executive Fellows Program (NEFP). The element missing is active mentoring once a CNE is in their role unless they employ an outside consultant. In that situation, the support is theoretical and not related to their day-to-day work.

The purpose of this project is to build the foundational elements of a mentoring program for current CNEs in a large health system. The primary audience is the CNE in a new role or new to the organization with online resources and active mentoring designed to be accessible to and benefit all CNEs in the organization. The value of this project will be expressed in outcomes related to CNE job satisfaction, retention, and cost avoidance related to lower turnover and termination of an outside executive consultant contract in place to support new CNEs.

Section II. Introduction

Problem Description

In a complex and multi-layered healthcare organization, transitioning to the role of CNE has been found challenging by those new to the role or new to the organization. There are established routes to identify and place high quality internal candidates in CNE positions, but the challenge continues to be an effective way to retain CNEs. Nurse leaders are at risk for leaving when their work environment is not ideal, they have poor work-life balance, and they do not have sufficient quality work relationships, such as those found in mentoring (Hudgins, 2016).

Northern California (NCAL) Regional PCS (RPCS) has experienced unprecedented turnover at the CNE level over the last several years. Between 2013 and 2016 there was an average turnover rate of 38% (Kaiser Permanente, 2016). The highest turnover rate was in 2015, following a work stoppage by the California Nurses Association (CNA) and the subsequent (yet unrelated) hiring of a new regional president and a new chief operating officer (COO), that upended the reporting structure in PCS. A staggering 61% of CNEs left their positions when the leadership change was made. The existing regional chief nursing officer role was renamed and restructured to be more operations focused and the title was changed to executive director of patient care services operations, who would report to the regional CNE. A regional CNE/vice president of clinical integration position was also developed as a direct report to the president of the region. Other regional PCS roles remained stable. The data clearly demonstrates that the most pressing need is to decrease turnover at the level of the local medical center CNE – those leaders closest to the members, patients, their families, and the front-line staff of CNA nurses (Appendix A).

Following the CNA work stoppage in RPCS in 2014, the feeling of unrest was palpable until the contract was ratified in January of 2015. Any health system is vulnerable following a work stoppage by registered nurses. There is a general feeling of unease, lack of trust between managers and employees, and a general disruption to relationships that can impede the momentum to goal attainment. A barrier to healing the organization was the number of CNEs that left the organization in 2015 (Appendix A). When a CNE leaves there is a reported decrease in job satisfaction by RNs, and a CNE departure usually predicates the exit of several leaders in the nursing department. For a hospital system trying to heal from a work stoppage and period of general unrest, this can be devastating to providing continuity of high quality care (Jones, Havens, & Thompson, 2009).

Initially the focus on the problem of CNE turnover was to look at ways to ensure a flow of candidates for succession to fill these roles. Establishing a rich pool of high-potential performers is an important way to ensure that nurse executive roles have internal candidates for consideration (Trepanier & Crenshaw, 2013). Two new programs were launched with success to prepare future internal candidates for succession planning and advancement into nurse executive positions, the NEALDP and the NEFP (Javed & Wallace, 2016).

Both the NEALDP and the NEFP are designed to assist in the development of leadership skills and competency of nurse leaders who have been identified as high-potential leaders in the departments of PCS, quality, and continuum of care (case management, home care) across the organization. Of the 11 initial candidates, four were promoted. Three of the NEFP candidates were placed in executive roles, and two were promoted to the NEFP from the NEALDP. All 11 remain engaged in the development program (Javed & Wallace, 2016). Both programs provide a safe environment to practice their responses without judgment to help them effectively build

executive leadership skills (Waxman & Delucas, 2014). One downfall is that currently there is no access to these programs for candidates out of the Kaiser Permanente organization, and just this year the first non-hospital based candidate was accepted as a CNE Fellow into the NEFP from the physician medical group that practices in the region. Another challenge has been the CNE vacancies have outpaced the availability of internal candidates. Broadening access is being included in strategic regional plans that address diversity and succession planning (Waxman & Delucas, 2014).

The challenge then became to address support of CNEs currently in their roles on the frontline, with attention to the CNE that is new to the position or new to the organization as a retention strategy. There are several programs open to executives, including the CNE. These include the Advanced Management Programs (AMP), Strategic Leadership Program (SLP), and Executive Leadership Development (ELP). These prestigious programs are sought after and well attended, however they are not focused on nurse executives who are uniquely positioned in the organization as leads in patient quality and safety strategies (Jones, Polanich, Steaban, Feistritzer, & Poe, 2017). They help the nurse executive understand the general culture of the organization, but do not help them socialize among their nurse executive peers.

Often a new CNE does not know who in the facility they can turn to with full transparency. In a study from 2017 on moral distress experienced by CNEs, participants identified that a mentor outside the organization may be of assistance until they establish relationships within their new workplace, however an outside mentor cannot always assist in the enculturation to an organization they do not know (Prestia, Sherman, & Demezier, 2017).

An effective mentoring culture within an organization can inspire future leaders to consider a leadership position (Trepanier & Crenshaw, 2013). RPCS leadership also wanted to

involve long-tenured CNEs in the process to keep them engaged and excited – as well as use their rich experiences to support their colleagues who are new to the role or the organization. Incumbent nurse executives engage in mentoring to invest in and protect the future of nurse leadership, safeguarding their legacy (Mcloughlen, O'Brien, & Jackson, 2010).

An outside consultant met with the new CNEs on a regular basis for the first several months of their tenure, and while she was a former regional employee, she never held the role of CNE. She could provide theoretical leadership support and provide historical context on the organization, but could not provide the practical advice and guidance that a CNE needs to be successful in daily operations and responsibilities. A mentor that is also an experienced CNE is uniquely qualified to give support, be a friendly face that understands the challenge, and provide feedback on how a new executive can improve their performance as a CNE. A coach or colleague that has not been a CNE is not the best person to mentor a new CNE to the role within an organization (Colakoglu & Gokus, 2015).

In 2016, nurse leaders across NCAL were inspired by Bonnie St. John, who presented at a local leadership conference on micro-resilience. Micro-resilience is a strategy that consists of five frameworks that help people to find elements of joy throughout the day that make handling the stress of life and work easier (St. John, 2017). There was a level of frustration being expressed by CNEs and their leadership teams in the medical centers.

In response to the frustration voiced by the CNEs, the regional CNE designed a program that would be uplifting and inspirational to the nurse leaders in attendance. The five strategies were embraced by the CNEs. The Frameworks are:

- Refocusing the brain – efficient thought processes
- Resetting primitive alarms – changing response to situations

- Reframing the attitude – focusing on the positive
- Refreshing the body – eating for fuel and nourishment
- Renewing the spirit – the power of purpose

By teaching CNEs and other nurse leaders how to have micro-resilience breaks throughout the day, the outcome would theoretically support a more resilient workforce. This is a group of colleagues who rarely ges to network together outside of their own facilities. This inspiration fueled the idea to seek to offer another avenue of resilience by way of a mentoring platform that would be available to all CNEs in RPCS. There is a correlation documented in the literature between resilience of the leader, their job satisfaction, and potential for turnover (Hudgins, 2016; Cline, 2015).

Merriam-Webster (2017) defines resilience as "1) the capability of a strained body to recover its size and shape after deformation caused especially by compressive stress and 2) an ability to recover from or adjust easily to misfortune or change." How better to describe what a CNE leads his/her teams through – compressive stress, misfortune and change! The American Psychological Association (2017) describes resilience as "the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress – such as family and relationship problems, serious health problems or workplace and financial stressors." Building a foundational framework of support in a program designed to promote a mentoring culture in the organization will assist PCS leadership teams to have resilience at all levels of experience and in all roles. Mentoring and supportive relationships can help instill resiliency in the CNE. A resilient CNE cascades the ability to respond well in adversity and models that performance through the entire workforce. The resilient nurse leader can use adversity to strengthen her leadership skills (Cline, 2015).

An additional driver of the work are inconsistent processes in the medical centers surrounding high risk/low frequency events that can leave the organization vulnerable. These include registered nurse terminations, California Board of Registered Nursing (BRN) issues such as reporting requirements, news on delays in licensure issuance, labor relations hot topics, sentinel events, and regulatory agency visits. Instead of the CNEs relying on a monthly meeting to get their questions answered, hit or miss phone calls, and/or general emails sent out to colleagues seeking information, there will be personal and electronic, virtual and in-person access to resources and support.

The RPCS mentoring foundation will provide additional opportunities to support the CNEs and provide alternative formats for engagement to mentor the new CNE (new to the role, or new to the organization), and provide support, opportunities for engagement and resources to incumbent CNEs. The mentoring program will give long-tenured CNEs a chance to contribute to their new colleagues' socialization. The executive director of regional patient care services (the author) will be the leader responsible for the implementation and ongoing work of the CNE mentoring program in RPCS.

The first step in assuring the organization is ready for a change is to apply a model for change assessment. Zachary (2005) describes a three-facet approach in developing a mentoring program that can be used as a tool to diagnose and evaluate the systems in place to support the change. There are three elements in Zachary's (2005) model for change: readiness, opportunity, and support (ROS) that suggest the foundation is set for the change in approach in retention of CNEs (Appendix B).

Available Knowledge

While the future of healthcare policy remains uncertain, astute leaders today recognize the way care is delivered in United States (U.S.) hospitals will continue to transform. The focus will be on greater accountability in the clinical performance of both providers and organizations. At the corner of that crossroads stands the CNE as the key driver of nurse sensitive quality outcomes, patient engagement, and fiscal stewardship (Quatara, Rea, Wilkins, & Facteau, 2017). CNEs are uniquely positioned in their strategic role at the highest levels of an organization to influence changes necessary to increase productivity and improve quality (Luanaigh & Hughes, 2016). A CNE new in their role or new to an organization can benefit from the support of peers in a mentoring relationship to increase their sense of belongingness (Vinales, 2015).

Performing a literature review provided an abundance of available resources – with most being published in the mid to late 2000's. Even the most current scholarly article on the topic of CNE turnover references this period of what could be considered seminal studies as they were unique perspectives at the time of publication. Appendix C is the summary of evidence. This represents fertile ground for future studies on succession planning, nurse executive retention, effects of nurse executive turnover, and further exploration of strategies to engage CNEs and promote role satisfaction, especially within the context of the ACA (Martin & Warshawsky, 2017).

The Importance of the CNE Role

CNEs play a critical role in promoting safe, quality patient care, exemplary care experience and operational efficiencies by bridging the gap between the goals of the organization and the practice of professional nursing, yet this is often done in a virtual silo within the acute care setting (Crawford, Omery & Spicer 2017). It is the CNE alone at the highest executive level

who brings the voice of both nursing and the patient and family populations to all decisions from the bedside to the boardroom, all within the context of the culture in an organization.

The 2004 seminal report by the Institute of Medicine (IOM), *Keeping Patients Safe*, calls on the CNE to bring the nursing perspective to the organization's care delivery system to optimize safety. A nurse executive needs both business and clinical acumen across several service lines, and to understand systems, budgets, project management, and models of care while maintaining exemplary interpersonal skills. The most successful healthcare organizations value the CNE and their expertise, and where the CNE is viewed as partner to the Chief Executive Officer (CEO) and medical leadership (Luanaigh & Hughes, 2016). The pressure to be an effective executive nurse leader is immense and without support can lead to turnover in this critical role. During a tenuous time-period, such as being in the middle of a bargaining period, it becomes more critical – and more difficult – to enculturate a new CNE (Cantu & Batcheller, 2016).

The Impact of CNE Turnover

When a CNE leaves, staff nurses job satisfaction decreases by approximately 29%, and 35% of staff nurses and other hospital nurse leaders report being concerned that the CNE departure demonstrates that the hospital or the nursing department is in crisis. Another compelling reason to retain the CNE in an organization is that when a CNE leaves, approximately 17% of their direct reports leave with them, further contributing to the disruption of the nursing department. When a nursing department is in chaos, consistent clinical practice becomes more difficult to maintain (Jones, et al., 2009).

Despite the overwhelming changes in the healthcare environment that the CNEs directly influence, there is little research about how CNEs manage the increasing complexity of their role

in daily work since the ACA inception. There is also limited information about the importance of resilience in nurse leaders and how they can exercise self-care during stressful times. Prestia (2015) sought to discover how CNEs are surviving in the acute care medical centers today. The first theme to emerge was that CNEs love the profession of nursing, and have a passion for their work and they enjoy sharing that love of nursing with their colleagues. The study also supports the model of the RPCS CNE mentoring program as the study demonstrates that incumbent CNEs enjoy mentoring new CNEs and other leaders because the activity sustains them and gives them purpose (Prestia, 2015).

To decrease the effect that CNE turnover has on an organization, the RPCS leadership team is called to inspire CNEs to stay in their role, or prepare them for the next level of leadership within the organization. The instability in the healthcare environment today implores system and regional CNEs to consider courageous models for leadership investment implementation that assist their medical center CNEs to diversify their skills and knowledge. To do this effectively they need to develop critical insight into operations, and improve their interpersonal relationships with their colleagues. This can be most effectively done through a mentoring relationship that benefits both the new and seasoned CNE (Huston, 2008; Jackson, Clements, Averill, and Zimbro, 2009; Prestia, 2015).

The Importance of Mentoring

One area that has provided role confusion is in the term “mentor” as being difficult to define within the nursing leadership realm. The term “mentor” comes from ancient Greece. Mentor was the name of the tutor who Odysseus engaged for his son Telemachus, and came to mean a senior person instilling wisdom in a junior person (Somner, Markopoulis, and Goggins, 2013). The seminal work of Mezirow (1994) demonstrates adults long to understand meaning in

their experiences through transformative learning that happens with open and honest dialogue about varying viewpoints and context of a situation. A mentor who is an incumbent CNE is uniquely qualified to provide a reasonably accurate context of any given situation the new CNE may encounter, albeit limited by their own perspective or experience with a given situation.

Inherent to the role of a registered nurse is a leadership quality as a natural element of nursing practice, yet there has not been a distinct focus on leadership development by way of mentoring in the nursing literature (Lemire, 2005; Valiga and Grossman, 2007). A mentoring culture provides an environment where self-directed, relationship focused learning can occur that is driven by the needs of the mentee or the experience of the mentor (Zachary, 2005). A new executive nurse leader that has positive mentors in their network can enhance their resilience through that relationship (Hudgins, 2016).

An effective mentoring program can help bridge the gap between the novice/advanced beginner CNE and the organizational goals that can accelerate the CNE's influence on the quality and effectiveness of care, increase nurse satisfaction in local medical centers, and represent system vitality. A foundation of mentoring supports the growth and development of leaders, strengthens the relationships between leaders, and connects CNEs to the organization (Zachary, 2005). A connected CNE, with resilience, is more likely to stay rather than look for fulfillment outside the organization (Hudgins, 2016).

The learning-centered partnership in mentoring provides the opportunity for colleagues to work together to achieve development goals that assist in gaining skills, knowledge, and thinking practices (Zachary, 2012). As leaders work together to gain insight and knowledge into their practice, they can spread that knowledge to others in their leadership team and strengthen the CNE Peer Group in RPCS, growing in resilience and effectiveness (Davis and Maisano, 2016).

Johnson and Gandhi (2015) discuss how formal mentoring programs can improve skills in both leadership and communication and suggest mentor programs as a possible way to increase diversity in leadership, another related goal in RPCS. In classical or informal mentoring, individuals are drawn to each other through shared interests or values that comprise the individuals in the relationship (McLoughlen, O'Brien, & Jackson, 2011). The mentoring program will eventually blend these two distinct approaches to mentoring by allowing for informal mentoring between nurse executives within a structured context of resources. Mentoring will also offer the opportunity for collaboration among CNEs for a range of experience regardless of tenure in the organization. A mentoring relationship not only benefits the two nurse executives engaged in the connection, it can also enhance the progression of nursing practice across the organization (McLoughlen, O'Brien, & Jackson, 2010). The nurse executive mentoring program will complement the two current succession planning programs and influence the tenure of nursing leaders in RPCS for years to come.

Rationale

Conceptual Framework

The theoretical framework for the mentoring program is a Caring Executive Leadership Progression Model -- a blended theory of Patricia Benner's (1982) Novice to Expert Model, with Kouzes and Posner (2007, 2009) Model of Exemplary Leadership. Appendix D crosswalks Benner's theory with elements in the Kouzes and Posner work. As the CNE new to RPCS moves through the progressive stages from novice to expert, each element and stage builds upon the previous experience and contributes to CNE success, ultimately leading to a sustainable retention plan in RPCS. Benner's foundational model has been attributed to successful retention in the clinical staff nurse role and is applicable to executive nurse leadership milestone

measurement as it is highlights the complex nature of the discipline of nursing (Benner, 1982). The more seasoned/experienced RPCS CNEs can benefit from their contribution to the growth and development of newer CNEs and fully realize their own potential as leaders and mentors (Wroten and Waite, 2009).

The timeframes mirror the range of conditions in Patricia Benner's Novice to Expert Theory and is based upon an institutional assessment of RPCS in collaboration with the Regional CNE. Many of the CNEs that qualify as a novice in a new organization, may be competent to proficient (if not expert) outside of RPCS. Becoming a novice or advanced beginner again in a new organization can be challenging for seasoned CNEs (outside of RPCS) to acclimate successfully. A seasoned CNE comes into the organization and is treated respectfully, but warily and sometimes wearily, by seasoned CNEs. The feeling of lack of self-confidence can be detrimental to the enculturation of the new CNE into an organization. The current culture can be like a steamroller to those new to the RPCS system. There is an attitude in some of the long-tenured CNEs that everything that was worth trying already has been tried in the organization. When a CNE new to RPCS shares ideas, it can be to a jaded audience, which can be demoralizing.

Anecdotally, one external candidate CNE worked for only three weeks at a hospital in RPCS. She was a very experienced CNE from the Southeastern United States. She appeared late one evening to the medical center she was assigned to, left her keys, phone and laptop with the chief operating officer (COO) and said she would not be back. No one knows what caused her sudden departure and while this certainly represents a minority of the experiences of CNEs new to the organization, there was a knowing giggle that rippled through the CNE peer group meeting when it was announced. It is not known if a formal mentoring program could have

prevented the CNE from vacating her role abruptly (conjecture there must have been something else happening in her life) but it certainly would have been one avenue this CNE could have reached out to for support that could have helped make the departure less impactful for all.

The two extreme ends of the spectrum (novice and expert) are where the majority of the CNEs are in terms of experience in RPCS. As barriers to implementation and curriculum planning for mentoring sessions, this will be a focus for content. There will need to be enough information to provide a thorough understanding of the organization's culture for the novice/advanced beginner, while still holding the attention of the seasoned CNE by demonstrating value of content to their practice.

Benner's theory (1982) describes how the novice nurse – in this case the new CNE – progresses through the stages to expert via a series of new skills and knowledge acquisition. A CNE new to an organization enters as a novice – not to the role, but to the organization. Theories of nursing leadership may be well known and understood, but a new culture in a new facility still takes time for the new CNE to learn (Martin & Warshawsky, 2017). In the novice stage, introduction to organizational nursing history, resource availability, and relationship-building takes place. The novice/advanced beginner CNE (new to the organization) will benefit from a mentor to offer discretionary judgment on unique situations that could be occurring on their campus as the novice CNE has no organizational or contextual knowledge of an event or how to respond. As the CNE moves further into the advanced beginner stage, they begin to recognize patterns of experience and can apply them to new situations, but may need guidance setting priorities and/or need the influence and guidance of a mentor in determining a course of action (Benner, 1982).

The competent CNE, usually in practice at the organization for one to two years by Benner (1982) standards, can prioritize actions and use deliberate planning to work efficiently in an organized fashion. Sometimes multiple priorities can be difficult for the competent leader to handle at once and still focus on long-term plans, but this improves as the competent CNE moves into the proficient stage, where they can engage in macro system thinking (Benner, 1982).

The final stage, expert, represents the CNE that uses their extensive knowledge and experience to engage in intuitive decision-making. The time in the role is less of a predictor of stage for the CNE than skill acquisition (Shirey, 2007). One can consider the experiences as a CNE in this organization as accelerative to skill acquisition. The presence of a mentoring program can help assimilate these skills quickly and thoroughly so they are retained, especially when combined with other formal leadership programs in the organization.

The blend of Benner (1982) with Kouzes and Posner's (2007, 2009) "Five Practices of Exemplary Leadership" is complementary to the Watson's Caring Science model embraced in the RPCS nursing model of care. Credibility and trust are what enables the nurse executive to move between the stages over time from novice to expert and is based on positive relationships with others, a hallmark of mentoring (Williams, McDowell, and Kautz, 2011). The connection is easier when the CNE knows the mentor has been in their shoes and is speaking from a place of experience.

Transformational leadership is at the center of the Kouzes and Posner (2009) framework of Exemplary Leadership where relationships between novice and expert CNEs can thrive. Throughout the five levels of novice to expert progression, there is the opportunity to model the way in a reciprocal relationship. Colleagues are encouraged to examine and share their professional and personal values, and reflect on behaviors that demonstrate their principles. The

CNEs can also build a shared vision, seek alternative solutions inspired by creativity, enable each other to act with accountability, and develop a sense of recognition and appreciation (Kouzes and Posner, 2007, 2009).

Using Benner, along with Kouzes and Posner's theory, in a blended framework of Caring Executive Leadership Progression supports Tizer, Shirley, and Hauck (2014) who assert that programs designed to enrich knowledge through workshops, mentoring, and group activities increase leadership confidence and competencies in executive roles. Incorporating mentoring strategies with self-assessment opportunities assists in growing the depth and breadth of CNE resiliency and effectiveness to reduce turnover and improve quality (Fenimore and Wolf, 2011).

AIM Statement

In response to the increased turnover in the role of CNE in RPCS over the last several years, the regional executive director of patient care services operations is formulating a foundation for a mentoring program as one aspect of a retention strategy for CNEs and CNE/COOs. By emphasizing the availability and accessibility of information with supportive and engaging social and caring activities, the foundation can be built for consistent leadership that drives standardization in the medical centers and throughout the region. The mentoring program foundational outcomes will be demonstrated in active mentoring by regional staff and a regional repository of forms, workflows, and other resources needed by a CNE. Timing of these resources are critical as 2017-2018 are bargaining years with the California Nurses Association (CNA) and the CNEs require support to navigate this tumultuous time on their campuses.

AIM statement for this project is: By March 5, 2018, there will be a 10% increase in ease of accessing resources, quality of work-life balance, and access to regional support as reported by CNEs and regional leaders through a pre- and post- implementation surveys comparison.

Section III. Methods

Context

The parent organization of RPCS cares for 4 million Northern California members, with 68,000 employees, over 17,000 registered nurses and 9,000 physicians. Leading those nurses in the 21 acute-care medical centers are 19 CNEs (Kaiser Permanente, 2017). The model is pure and direct: "provide high quality, affordable care using cutting edge technology in an integrated delivery system using evidenced-based medicine" (Kaiser Permanente, 2017). The mission is to "provide high quality, affordable health care services and improve the health of our members and the communities we serve" (Kaiser Permanente, 2017).

The CNEs in the medical centers in the service areas of RPCS report directly to the area manager/senior vice president of the service area, and have a dotted line to the regional CNE. In some of the smaller medical centers, the CNE is in a combined role of CNE/chief operating officer (COO). The CNE is part of the senior leadership team in the medical center, and has the following service lines in their direct reporting structure: adult services, maternal child health (where applicable), administrative services (staffing office, nursing supervisors, bed control), and perioperative services. The combined CNE/COO role also has continuity of care (case management) reporting to that role. Unique to the organizational model, emergency services, and interventional radiology report up through the medical group with little oversite from the hospital leadership team, however all nursing care that happens in licensed space (cardiac catheterization lab, emergency services) still falls under the CNE license according to The Joint Commission (TJC) and the Centers for Medicare and Medicaid (CMS). The relationship building that a mentoring program can afford is key for influencing leadership in medical group led departments where there is no direct reporting structure for the CNE. The mentoring

program will focus on the CNE, even those with the dual COO designation, and will concentrate the content on the unique aspects of the CNE role.

The current CNE support system at RPCS is informal. There is a monthly 6-hour peer group meeting in regional offices. Approximately three quarters of the CNEs attend the meeting in person. The others, because of local campus issues that prevent the CNE from traveling, attend virtually via webinar. In addition to some of the team being virtual, the challenge with this format for networking and support is the amount of information that the regional CNE and others need to share in this compressed time. Typically, there is minimal time for networking during the 30 minutes at breakfast, and the 45 minutes for lunch – often the CNEs use this time to catch up on emails or calls as they have committed to staying off their electronic devices to stay engaged in the meeting. Hospitals in the system span from Roseville in the north to Fresno in the south, so most of the CNEs also drive a fair distance in the infamous Bay Area traffic. No one lingers to talk when the meeting ends – everyone is anxious to get on the road. Even informal mentoring struggles to thrive in this environment.

Large healthcare organizations have a culture that can be challenging for CNEs and other nurse leaders to successfully acclimate into. Whether it is a seasoned CNE new to California and/or the RPCS environment, or an RPCS experienced nurse leader in a stretch assignment as an interim CNE or in his/her first role as a CNE, a purposeful mentoring program foundation can assist in the successful transition, enculturation, and retention of CNEs in a complex system (Klinge, 2015).

Interventions

The two drivers of the mentoring foundation that frame the priority setting for interventions are CNE retention and inconsistent processes and workflows in the medical centers

surrounding high risk/low frequency events that can leave the organization vulnerable. These include registered nurse terminations, California Board of Registered Nursing (BRN) issues such as reporting requirements, delays in RN licensure issuance, labor relations hot topics, sentinel events, and regulatory agency visits. Instead of the CNEs relying on a monthly meeting, hit or miss phone calls, and/or general emails out to colleagues to get their questions answered, there will be personal and electronic, virtual and in-person access to resources and support.

Initially the proposed work was planned as a formal multi-layered mentoring program. Appendix E illustrates the elements that are outlined in the prospective work breakdown structure:

- Electronic resources
- Threaded discussions in electronic format
- Active Mentoring
- Programs for CNEs in their first year at the organization
- Mentoring Moments in monthly CNE meetings

The first component was to be an electronic resource for materials with an interactive threaded discussion. The electronic repository was simple to set-up, but the threaded discussion was beyond the technology capabilities of the new platform deployed by the organization for shared work – the RPCS Box technology. The next component of the mentoring foundation available to all CNEs, wherever they fall on the novice to expert continuum, is participation in active mentoring. This element includes dedicated office hours for consultation via webinar, phone, or in person with the executive director of regional patient care services operations and subject matter experts in finance, human resources, regional service line directors, labor relations, and the nurse scholar's academy (NSA).

The scope of the initial proposal was too large to be realistic or effective to be implemented successfully within the required timeframe. The future scope of the mentoring program is promising. Expanding the mentoring program remains a viable part of the strategic plan for RPCS, especially as involvement of incumbent CNEs as mentors increases. Because of bargaining and an imminent possibility of a work stoppage, the electronic repository needed to be available to the CNEs as soon as possible.

Appendix F illustrates the revised work breakdown structure for the foundational elements of the mentoring framework. Once this work is in place as a support structure, the door can be opened to enhancing the program and will support a mentoring culture in RPCS.

Online Resource Building

The timing of the online resource build for CNEs coincided with the acquisition of a new piece of technology available to RPCS, the RPCS Box. The RPCS Box is powered by www.box.com and is a sophisticated platform to collaborate on documents, and maintain version integrity (Box.com, 2018). Unlike the former internal network shared drive where users could damage, lose, or destroy formatting and content of shared documents and spreadsheets, KP Box technology preserves every version of a document so work is never lost. RPCS Box is user-friendly and simple to manage. All employees can access the RPCS Box site from any computer, whether on the protected network or not. Given the nature of travel across the region, this is helpful.

Union bargaining and the possibility of a labor action motivated CNEs to ask for information related to the CNA contract, bargaining, labor relations, and potential work stoppage preparation. The first document placed on the RPCS Box was the planning document for a potential work stoppage. In the last bargaining year in 2014, the CNEs were given a binder with

the information needed to prepare their campuses for a work stoppage or other labor activity. Any update had to be done manually – making sure everyone had the most current version was a logistical challenge for a busy CNE or their assistant, and frustrating for regional PCS team members who did have the most recent version. A review of the options available was performed and a SWOT Analysis on the viability of use of the RPCS Box (Appendix G) was reviewed. The regional team determined that an electronic CNE binder for the work stoppage would be an excellent way to trial the RPCS Box technology and gauge its usefulness for expanded access in the mentoring program foundation.

The reputation of the regional PCS team's expertise will assist the RPCS Box to be successfully implemented and supported by local medical center stakeholders. Reputation is best evaluated on a continuum rather than a moment in time and can be a primary driver that the target audience will find valuable in the partnership (Zerwas & von Korflesch, 2016). Many of the regional PCS contributors to the RPCS Box were present at the last bargaining and work stoppage, while many of the CNEs in the medical centers were not in their roles in 2014. The CNEs new to the organization do not know what they do not know about preparing for a work stoppage in RPCS. The timing is perfect to set a new standard for resource sharing. Additionally, the program leader was a CNE at the time of the last work stoppage and has a reputation for being able to manage both labor relations and campus disruption which aids in the trust relationship between medical centers and regional PCS.

The model for reputation has identified the most relevant attributes to consider when evaluating the potential for success of proposals. These five categories are the leader and the team, market and industry, products and service, innovation, and finance and are illustrated in Appendix H (Zerwas & von Korflesch, 2016).

The final determination for the RPCS Box to be the main document repository for contingency and work stoppage planning documents was made by the regional CNE. As a back-up document, because of the critical nature of the information, regional PCS will prepare and distribute contingency/work stoppage hard copy binders to CNEs with an initial set of documents. As updates are made in the KP Box, an automatic push email will be generated to the CNE assistants at each campus who can maintain the binder in the event of a power or internet outage. The RPCS Box is also set up for individual medical centers to have a site-specific folder where important documents are uploaded for sharing best practices across their hospital or the RPCS region. For security reasons, access to the RPCS Box is limited to CNEs, non-bargaining administrative staff, and nursing directors at each medical center location. RPCS Box became part of the critical infrastructure of the regional command center's contingency organizational chart as shown in Appendix I.

Another opportunity with RPCS Box technology was improving the accessibility of documents from the monthly CNE meetings. The regional CNE's executive consultant formerly sent them via email, but in a mailbox with 100 or more emails arriving daily, it was easy to lose the information. Instead of receiving them on email, the CNEs now receive a link to the latest set of documents and minutes that brings them to the RPCS Box. The goal was to get them the information while continuing to drive traffic to the RPCS Box site.

After feedback from the CNEs and regional PCS team members, the folders in the Chief Nursing Executive Mentoring Program evolved and are labeled with plain English, few acronyms, and are high demand topics. Appendix J is a screenshot from the RPCS Box site of the mentoring program.

The RPCS Box

Folder - HR Questions – Concerns – Workflows. This folder contains documents and resources regarding coaching for excellence, termination workflows, and 'just culture' information to assist CNEs in preparing timely and robust documentation.

Folder - Labor Relations. The labor relations folder was first thought to be the site for all documents related to CNA and other unions the CNEs interact with through PCS. However, the CNEs requested more specific categories of folders. All the contingency planning documents are located on the main CNE RPCS Box site.

Folder - Position Posting. One process that changes frequently is position posting approval workflows. A folder dedicated to this topic, separate from HR, was seen as an important element through verbatim comments from the CNEs. Especially for new CNEs, this is often a vexing problem.

Folder – BRN Workflows. This is one of those high-risk/low-frequency processes, so has the potential for CNEs to have inconsistent practice. The regional CNE has a specific timeline of notifications and steps that CNEs need to assure are taken prior to initiating a BRN report. This is especially helpful for CNEs who are new to California.

Folder - Role Profiles. In 2016, the regional CNE started work in two innovation sites in NCAL medical centers. An integral part of the work that all CNEs were interested in seeing, were the standard work profiles for the critical roles of Assistant Nurse Manager (ANMs), Nurse Managers (NMs), Directors, Nursing Supervisors, and Clinical Nurse Specialists (CNS). A team of organizational effectiveness leaders and analysts along with each medical center's CNE and nursing leadership teams designed work that each role should continue, what work they should stop, and what they should start doing to improve care, improve patient satisfaction, and improve

their own job satisfaction. All role profiles are now available to the CNEs. Over the past year, this is the single most requested resource by CNEs at all levels of experience in the organization.

Folder - Audit Reduction Work. Another outcome from the two innovation sites designed to free up time of the front-line leaders (ANMs and NMs) was audit reduction. The innovation sites nurse leaders worked for months on these lists to inventory and standardize audits and daily tasks that were required in each PCS service line. It was then spread to the 19 other medical centers in the region. Both innovation sites saw a decrease of approximated 60% in audits/standard work by identifying what was really required, and what level of staff should/could be doing the work (Gooch, 2017).

Folder – RNLC 2017 Meetings. The Regional Nurse Leadership Council (RNLC) meeting minutes and all related documents are stored here. Access to the RPCS Box is driven by sending links to the document repository in email, rather than the documents attached to an email.

Folder – Journal Club. This folder is further broken down by categories: Clinical leadership, personal-professional growth, patient safety, and education articles. As the RPCS Box use continues to expand, the plan is to encourage CNEs to actively upload interesting journal articles.

Active Mentoring

Active mentoring of CNEs is led by the executive director of regional patient care services operations. Part of this role is being an emergency response resource for CNEs who have a problem at their campus, especially if the regional CNE is not available. Other touchpoints have been informal when a CNE reaches out, or the regional CNE asks for a specific

issue to be addressed in a mentoring conversation. An example of this was in early 2017 over a long weekend when there was a massive server outage in RPCS – impacting telemetry monitoring in most of the medical centers. A virtual incident command center was implemented, and CNEs communicated with regional leadership to strategize response from their medical centers from a regionally consistent perspective.

As a precursor to formal mentoring meetings that were requested by CNEs, weekly Friday virtual office hours were set up with the executive director of patient care services operations as an element of active mentoring. Fridays were chosen because they are typically the day with the least number of meetings around the region and at the local medical centers. The design of the call is informal – a bridge line is opened at 10 am and remains open until 12 noon. There is no set agenda and no topic is off limits. The first virtual office hours were on October 27, 2017. Two CNEs called in – both CNEs with less than two years experience, and one nurse fellow. Some of the topics covered were politics at work – working with regional and program offices, other leaders presenting the CNE's work as their own, and patient throughput.

Another CNE with less than one year in her role wanted to verify the time of an upcoming joint operations meeting with finance and wanted to be sure she had all the information she would need to present because she did not want to be caught off guard. She also wanted to discuss strategies on how to cope with the style of a new area manager, and talk through some options in dealing with a cantankerous CNA nurse representative on her campus. The mentor shared experiences in dealing with different area managers and allowed her to work through her own action plan by active listening.

The nurse fellow is a high energy, high potential leader who since that call has become a new CNE at a RPCS campus. She had just been deployed to Santa Rosa for the North Bay Fires

to assist in the re-opening of the KP hospital, and wanted to talk about the great teamwork she witnessed up there.

The next week of calls had one caller – another CNE fellow, and the following week had zero calls. After meeting with the team of regional leaders, we determined that having focused virtual office hours might be more lucrative to the CNEs. Subject matter experts were identified in HR/labor relations, CNA contract, professional practice, finance, HR, accreditation and regulation, nurse scholars, and care experience.

December 1, 2017 was the first subject matter expert call, and there were four CNEs who called in to speak to leaders in HR/labor relations and professional practice. The key was discovered! Most of the two hours was taken up with robust discussion about some personnel issues in the medical centers, work stoppage preparation, and the decision tree that helps a CNE decide on when to consider a report to the BRN. The upcoming schedule of Friday calls with the subject matter experts/topics identified was published so CNEs could see what day they might want to call in based on what is happening on their campus.

Unintended Consequence

The regional CNE identified the need to have a consistent onboarding process for nurse leaders across the region, while continuing to recognize the value of a mentoring program for CNEs. To assist both streams of work, she identified a full time equivalent (FTE) that would be filled by a current, long tenured CNE who was looking for a new opportunity within the organization. Once the onboarding curriculum is finished, this regional director level FTE will fill the role of a CNE liaison and be integrated into the enhancements of the mentoring program for CNEs.

Budget/ROI

The initial plan forecasted the final three quarters of 2017 and the first quarter of 2018 would be intensive for this body of work, and that was accurate. The projected resource requirements were primarily focused on personnel expenses to build the resources, and that was accurate. Factored into the budget analysis is the work time for an executive consultant (80 hours), RPCS Box administrators (120 hours), administrative assistant (40 hours), and executive coach to consult on work plan (6 hours). The RPCS Box resource replaced an outdate 'wiki' site that was not widely utilized by leaders in NCAL PCS and this project has already increased the access of this valuable resource by medical center CNEs. The current interest in the project is driven mainly by forms, workflows, and planning documents related to a potential work stoppage the teams are preparing for in 2018.

Initially, the cost avoidance was estimated to be limited to CNE turnover, and ROI factors in CNE retention. For calculation purposes, CNE replacement is estimated to be 150% of CNE salary (Arnold, et. al, 2006). By 2020, projections are that meeting nursing turnover demands will cost the United States $100 million dollars annually. There are also indirect costs attributed to leadership turnover, such as loss of operational efficiencies due to workflow and partnership disruptions. The disruption of continuity in leadership can also harm brand perceptions (B.E. Smith, 2017). However, through personnel movement out of RPCS, and the promising future of this work and other regional PCS leadership needs, an FTE was repurposed to be a CNE Liaison and Leadership Development subject matter expert. That FTE change was budget neutral to regional PCS. A current CNE in RPCS was awarded the position in January, 2018. Hiring that person negated the need for an outside executive coach for new RPCS CNEs,

which was an actual cost avoidance of approximately $98,000 annually (Kaiser Permanente, 2018). Appendix K is the detailed budget.

Study of the Interventions

The nature of the two mentoring strategies that provide the foundation of the CNE mentoring program, were created based on the current availability of resources and time during this critical bargaining year (Hooley, Hutchinson, & Neary, 2016). The two methods were also driven by other needs that were identified by current medical center CNEs, and the regional CNE, with input from the operations, finance, and professional practice regional executive directors.

Online resources are a critical delivery instrument which makes accessing resources easier, and offers new types of asynchronous support. Mentoring also extends to various electronic methods such as email, video conference, and other virtual communication models (Hooley, et. al, 2016). Literature supports electronic/virtual support of career growth via computer interaction/information, and the combination of face-to-face and online interactions (DiRenzo, Weer, & Linnehan, 2013). The electronic format of RPCS Box in the Chief Nurse Mentoring Program is not an online version of an electronic mentoring platform, but rather a complementary and foundational element to build upon for future iterations of the formal mentoring program.

It is important to note that whatever the method of mentoring – it can be done well, and it can be done poorly. Mentoring can be effective whether it is informal or formal (Hooley, et. al, 2016). There is no mandatory element of the mentoring program currently – and the regional chief nurse is never anxious to add another ‘must do’ to the CNE task list. The current version of the program is informal and driven primarily by CNE actions or requests. The only future

element that may be mandatory could be for the nurse fellows or CNEs who are in their first year of practice in the role, but that is still to be determined.

The most critical aspects for the regional team to consider when designing resources for the CNEs were twofold: The time the current body of CNEs have been in their role, and what they verbalized as important in their role while assessing their overall feeling of well-being and work/life balance.

Measures

As described as an element of the GANTT chart (Appendix L), the first step is ascertaining a baseline of CNE perceptions by way of electronic survey to identify the CNE's perceived priorities for the mentoring program foundation electronically. An additional driver was identifying topics for standing office hours. The evaluation criteria also focuses on perceptions of availability of resources, job satisfaction, and general feelings of wellness and support.

The pre-surveys (Appendix M) were administered via online survey before the start of the first mentoring material offered to the group in May of 2017, and post deployment surveys were sent out in February 2018, with a return date of March 9, 2018. Additionally, verbatim comments will be elicited in both informal interactions, via email queries, and space allowed on surveys. The results will be shared with the regional CNE, at the CNE peer group meeting, and with the chair of the DNP committee.

A request from the regional CNE for brevity and to keep the survey to 10 questions or less. The only identifying factor is length of time in current CNE role. The areas of focus are:

- The voice of the customer (what the CNEs' priorities are for information access/support).

- CNE availability (volunteers from the expert to serve as mentors, willingness to participate in an additional monthly call for the novices).
- Perception of availability of resources in current state (and again after implementation).
- Perception of job satisfaction (pre and post implementation)
- Perception of general health, well-being, and support as evidenced in work life balance perception

The post-deployment surveys are designed to see if there is any improvement in the ability to access resources. Additional areas of focus are the CNE's general feelings of connectives, well-being, support, and work/life balance. The results will help drive next steps in further mentoring program elements to retain nurse executives and decrease turnover.

Analysis

The main purpose of the pre-deployment survey is to help the regional team understand what resources were of the most value to CNEs. The ranking of their preferences is shown in Appendix O. The two highest ranked resources requested were a journal club repository and monthly mentoring meetings. The goal was to understand what the gap was between current state and what the stated needs were to improve the drive to deliver best and consistent practice in the medical centers (Dickerson, 2012). The pre-deployment survey was administered via paper and in an online survey, and the audience was primarily CNEs. Of 38 surveys distributed between April and May 2017, there were 25 completed surveys returned.

The primary reason for the post-deployment survey is to assess if the gap had been filled and to identify future work streams to support the mentoring culture in RPCS. There were some challenges with data interpretation in the post survey because of the large number of skipped questions. There were 42 post-deployment surveys distributed and 26 people completed the

post-deployment survey. There was a higher number of total skipped questions throughout the post-deployment survey. One possibility is that the questions were framed more toward the experience of current CNEs. The language in the post-deployment survey was altered to make the same questions answerable by a broader audience to have a larger response rate. The survey was shared with all of the CNEs, and several regional leaders in PCS who are not CNEs. These include several students currently enrolled in the Executive Leadership Doctor of Nursing Practice (EL-DNP) Program at the University of San Francisco (USF). In an effort to achieve more robust data in numbers, the quality of the information may be diluted. By including more leaders who utilize the RPCS Box technology and often access the same resources the CNEs use, the rationale behind including the non-CNEs is that patterns of association could help the researcher understand the underlying priorities of frequent users of the information (Polit & Beck, 2014).

There was only one question that was not skipped when answering the questions in both the pre- and post-deployment surveys – and that was the very first question that asked the respondent to indicate their total number of years in current management/leadership level in any organization. Given the relatively small number of respondents, perhaps there was fear in losing anonymity if years in the organization was disclosed. CNEs were verbally informed that no identifying information would be shared, however there can still be suspicion when personal information is being queried. Assuring absolute confidentiality in studies where identifying information such as tenure is challenging (Polit & Beck, 2014). This information was necessary to correctly determine what stage of development a CNE is in novice, beginner, competent, or expert. To protect respondents as much as possible, individual survey responses will not be

published. There were no verbatim comments shared on either the pre- or post-deployment surveys by respondents, again attributable to possible fear of lack of anonymity.

Ethical Considerations

Responses on the surveys were anonymous. The Kaiser Foundation Research Institute and the University of San Francisco Doctor of Nursing Practice Department approved the statement of determination as a non-research performance improvement project; it was considered exempt from Institutional Review Board (IRB) approval – Appendices P and Q.

Section IV. Results

Both the Pre- and Post-Deployment surveys were designed to prioritize the needs of the CNEs and assist in determining efficacy of the RPCS Box as an online resource. The Pre-Deployment survey was formulated from the experience of the author, an experienced CNE. The Post-Deployment survey was built based on the perceptions of usefulness of the RPCS Box to current CNEs, regardless of tenure. There was also a goal to determine if finding access to online resources was perceived to be easier, would CNEs feel more connected to their work and colleagues, and have more work-life balance.

Pre-Deployment Survey

The journal club repository was a top priority for what the CNEs wanted to be able to access. Making a folder in the box where regional leaders and CNEs could upload favorite articles was simple. The folder was divided into the sections of Education, Patient Safety, Leadership and Professional-Personal Growth. There are currently 10 articles uploaded in this section of the online mentoring resource in RPCS Box

The monthly mentoring meetings were rated as highly as the journal club repository. Due to competing priorities of the regional CNE and current bargaining with CNA, the monthly mentoring meetings will be added to a future iteration of the mentoring program. The mentoring program will be integrated into the monthly CNE meetings or monthly CNE phone call. The weekly virtual meetings with the executive director of PCS operations is a placeholder for future mentoring meetings. Acknowledging that the CNEs wanted formal mentoring, the virtual office hours evolved into being clustered by subject matter experts in attendance. The next step will be to have a 15-minute topic presentation at the beginning of the calls, and then open to questions to provide more structure to the time together. This may also drive more attendance depending on

topic. The CNEs are generally very interested in anything related to current financial strategies and labor relations updates.

Labor relations was expected to be ranked as a high priority, and the topic came in at number three, tied with staffing resources. These two topics are of highest relevance because of the issues at the bargaining table this year, and probably the biggest area of opportunity to establish consistent practices across the region. The labor relations folder is the most active, both in resources added and access by CNEs around the region. The body of work under the staffing resources umbrella is going through tremendous changes in the next year. While out of scope for a robust presence in the standard CNE mentoring program, the executive director responsible for this area of financial stewardship is engaging in constant conversations with CNEs and their teams.

An online discussion thread was also identified as a top priority for CNEs. A threaded discussion is a format most have used on various social media sites, and provides an avenue of informal interactions between peers – those new to the organization and those who are considered 'insiders' who play the role of agents of socialization (Colakoglu & Glokus, 2015). The current technology platform available at RPCS does not support this capability and it will be considered for a possible future element with system enhancement. There was discussion about a private or secret Facebook group of RPCS PCS CNEs, but the lack of security inherent to social media sites quickly eliminated pursuing the idea further.

Post-Deployment Survey Results

As mentioned previously, in both surveys the first question was answered by all 26 post survey respondents, though several more decided to skip questions in the post survey than they did in the pre-deployment survey. One possibility is the author was involved in CNA

negotiations several days a week and could not be as hands on in guiding expectations and importance around the completion of the entire survey. The post-deployment survey was also sent to several non-CNEs in regional leadership. For future versions of the survey, there will be a not applicable (NA) option. By forcing people to choose a response and not have the option of indicating an NA option, the job of interpretation becomes more difficult. One must consider, are people skipping the question because they have a bad attitude about the answer, was the question just worded badly, or did respondents feel they had no choice that correctly reflected their perceptions (Ellis, 2015).

The post survey results informed the team in a tangible manner whether the resources were valuable or being accessed. This helped RPCS leaders determine allocation of resources to continue building the RPCS Box. The respondents were asked to indicate how helpful the online resources were in the topics of labor relations/work stoppage, termination workflows, board reporting, staffing resources, journal club, and weekly virtual office hours with the executive director of regional PCS operations. Using a Likert Scale from zero to five (0 – not at all, 1 – rarely, 2 – occasionally, 3 – sometimes, 4 – regularly, 5 – always) the topics were ranked – see Appendix R. As would be expected during a year of labor activity and potential work stoppage, labor relations and work stoppage documents were indicated as the most helpful to CNEs in the electronic repository.

Additionally, the team wanted to assess CNE quality of life measures to see if there had been any improvement since the foundational elements of the CNE mentoring plan had been implemented. Appendix S compares the results. The results are shared with the regional CNE. There are some concerning outcomes related to work/life balance that will be discussed in the key findings.

Section V. Discussion

Summary

Key Findings

The AIM statement that was the basis for this DNP project reads: By March 5, 2018, there will be a 10% increase in ease of accessing resources, quality of work-life balance, and support of regional support as reported by CNEs and regional leaders through a pre- and post-implementation surveys comparison.

The AIM was achieved in these two key indicators as demonstrated by a ≥10% increase in rating by survey respondents:

- Ease of finding forms, processes, and workflows: 25% improvement
- Feeling of connection with colleagues: 19% improvement

Two other areas remained relatively flat between pre and post surveys regarding accessibility and/or availability of PCS regional leaders and the level of satisfaction CNEs have in their role. This is seemingly in conflict with a 5% decline in overall CNE perceptions of a resource that helps them feel connected. The term resource was not defined, and further inquiry on whether this reflects the CNEs feeling they lacked access to electronic resources or availability of a regional contact needs to be explored.

The most compelling decline was in the category of CNEs perceiving they have balance between their work and home life – this indicator dropped by 50%. The post-deployment survey was administered at the end of the fourth quarter of 2017 and the beginning of the first quarter of 2018. Possible explanations are the end of the year performance results, staffing challenges, and financial pressures to close out the year fiscally strong. The ACA possible repeal and replace had health systems scrambling to prepare for a major paradigm shift in operations. Because of

these rapid changes looming, the CNE is seen as the champion of many of these efforts to align multidisciplinary providers for cost-effective care (Prestia, 2015). Neither the pre- or post-deployment survey queried how the CNEs define work/life balance, or if they have any specific strategies to assist in maintaining work/life balance. This topic requires more inquiry and focus and will be a topic in the monthly mentoring moments/meetings in 2018.

Labor relations resources were recognized by the CNEs in the post-deployment survey as the most helpful online resource, followed by termination workflows, board reporting, staffing resources, journal club, and virtual weekly office hours with the executive director of PCS operations. There were no written verbatim comments shared via the survey process.

Interpretation

The two areas that were achieved in ease of access to workflows and feeling connected with colleagues is promising as the mentoring program continues to evolve. This DNP project provided a backdrop for RPCS to trial the RPCS Box platform for use across the region. Placing the work stoppage planning documents on the website helped to drive traffic to the repository. In this time of preparation for potential union activity, it is not surprising that the CNEs have a heightened feeling of connectivity with their colleagues. They are learning to lean on each other to navigate these troubled waters. Purposeful mentoring can significantly help empower both the protégé and the mentor in an organization. The more connections mentors and newcomers have, the more the willingness to participate in a mentoring program (Colakoglu & Gokus, 2015).

The KP Box was tested and passed as a helpful resource repository that CNEs will access. The noted improvement between survey periods of 25% in the ease of locating forms, resources and workflows is promising, and one of the primary outcomes that were hoped for. The 19% increase in feeling of connectedness with colleagues also speaks to the decrease in

CNE turnover to 20% since 2016 with the restructuring. While that percentage appears high, this represents an improvement of 15% from baseline, and is 18% below the reported rates by CNEs in a 2010 literature review (Batcheller, 2010).

One strategy the regional CNE has implemented is a CNE only portion of the monthly meetings, where only current CNEs in permanent positions attend. Regional staff is not permitted. This gives the CNEs time with their peers and the regional CNE where they can share more openly. The environment across RPCS is more transparent, open to fun, and the regional CNE makes sure everyone feels valued as a person – not just an employee. The collegial networking encouraged by leadership and supported by the mentoring foundational work is critically important to new and incumbent CNEs (Prestia, et. al, 2017).

The RPCS Box as a resource has been found to be successful and will be the foundational tool for a formal mentoring program. The RPCS Box provided a practical format for CNEs and other stakeholders to prepare for bargaining with the Union and for possible work stoppage planning. The CNE turnover has decreased since 2016, and CNEs are reporting feeling more connected with each other. The CNEs feel listened to, they have private time with the regional CNE every month, yet they still perceive their work-life balance is decreasing.

This decline in the feeling of work/life balance among the CNEs and the regional peers was shared immediately with the regional CNE. The post-deployment survey was administered during the months of the most overwhelming influenza season in many years. All RPCS hospitals are overflowing with flu patients, many sick calls at the hospitals, at the same time financial indicators across the region are off budget. Scrutiny of the CNE's job performance in the medical centers is intense. The perfect storm of these events could be part of the feeling of no work/life balance. Additionally, any executives or regional staff members involved in union

negotiations or who have labor activity on their campus could be feeling the strain of prolonged bargaining sessions and state of readiness for a work stoppage. The evidence demonstrates that when a CNE is under pressure, it is challenging to maintain balance in life – and emotional indicators such as fatigue, short-temperedness, anxiety and discord at home are often found in these trying times (Prestia, et. al, 2017).

Limitations

Limitations in this body of work include the beginning of bargaining with CNA in the summer of 2017. The author of this body of work was the lead negotiator for RPCS, as were several members of the regional PCS team that support the work of the mentoring foundation. The 18 member leadership team lead negotiations with CNA 2 days a week, each day lasting 8 to 10 hours. Two days a week were spent in bargaining preparation meetings with senior leaders, labor relations experts, attorneys, financial analysts and communications professionals crafting language and strategy. The other day in the week (Friday) was reserved for catching up on tasks and projects related the other aspects of overseeing PCS and hospital operations around the region, including moving the work forward on contingency planning and RPCS Box resource building.

Another limitation was not being able to provide the most requested aspect of a mentoring program - real time discussion threads – because of technology limitations. Timing of the post-survey deployment proved challenging because of the CNA bargaining, the influenza season, and competing financial situations requiring the CNE's attention.

CNEs were verbally informed that no identifying information would be shared, however there can still be suspicion when personal information is being queried. There were no verbatim comments shared on either the pre- or post-deployment surveys by respondents, again

attributable to possible fear of lack of anonymity. The absence of verbatim comments is disappointing. Upon reflection, perhaps interviews with CNEs would have been an easier way to hear their thoughts, although anonymity could still be a factor. While specific demographics were not asked, disclosing their tenure in the position could identify them. In addition, the primary investigator works closely with the CNEs in daily practice, which can impact their ability to be transparent with information. When employees feel they could be identified, response rates to survey questions decrease and non-response can be related to satisfaction in their role on a given day or their comfort with the investigator (Mueller, K., Voelke, & Hattrup, 2011). A strategy to avoid this in future iterations would be to employ a third party vendor conduct surveys and interviews.

To increase the number of survey responses, the post-deployment survey was sent out to other RPCS regional team members without explicit instructions on how to answer questions directed toward being a CNE, and an "NA" option was not included as a response option. Further surveys will include the instructional element, or may seek to exclude non-CNEs from the sample. Ultimately, the focus of the work is to improve the support and mentoring of CNEs, and while several members of the regional team may be future CNEs, they are not currently in the role.

Conclusions

The need for retaining high performing nurse executives is an imperative facing RPCS. Formal and informal mentoring initiatives are important to include for a reciprocal and collaborative partnership between incumbent CNEs and newcomers to the role or the organization (Klinge, 2015). In a time of increasing financial pressure in healthcare

organizations, funding of both succession and mentoring programs is getting more difficult, but has never been more important (Trepanier & Crenshaw, 2013).

An initial step is building the foundation and making forms, resources, and workflows easier for CNEs and providing them opportunities to engage in some aspect of formal mentoring activities are recognized as top priorities. Data demonstrates that incorporating workforce planning with a solid succession plan, continued mentoring and professional development can improve operational and financial outcomes (Kim, 2012).

In addition to the turnover already experienced in RPCS, one study of 622 CNEs/CNOs revealed 62% plan to vacate their role within 5 years (Jones, Havens, & Thompson, 2008). The pace of executive turnover throughout healthcare is expected to accelerate because of the volatility of the political environment. It is reported that 27% of CNE departures are related to a conflict with the CEO or financial pressures (Wright, 2017). For calculation purposes, CNE replacement is estimated to be 150% of CNE salary (Arnold, et. al, 2006). As the detailed budget in Appendix K shows, this amounts to approximately $385,000 per RPCS CNE that leaves their position. Mentors can be a factor that helps maintain CNEs in their roles. An effective mentor can help by providing the CNE with support, contextual understanding, and resources needed for them to be successful to analyze situations, evaluate strategies, and develop new knowledge to help improve organizational performance (Klinge, 2015).

Regional PCS is also called upon to be more visible to the CNEs in the medical centers as a source of assistance, although the survey reveals the CNEs feel supported and satisfied in their role at RPCS. Before a formal mentor plan can be implemented, the regional PCS leadership team serve the same function as a mentor, however they are not all former CNEs. The regional leaders that interact with the medical center leaders in each of the service lines help support the

overall direction of initiatives from the regional perspective. One way this is achieved through the work of building the foundation for the mentoring program was to redesign how regional initiatives are implemented in the medical centers. Instead of the information being shared at the monthly CNE meeting with the expectation they will take back the program or tools and spread the practice, the shift was made in October 2017 to push initiatives through the PCS service line peer groups. A new program or toolkit is introduced to the CNEs at the monthly meeting where they give approval to proceed. The initiative is then taken to the service directors (where applicable) in maternal-child health, adult services, perioperative services, and administrative services for implementation. This rescoping of responsibility for implementation has led to the leaders closer to the work being in charge of the process, rather than the CNE attempting to oversee the change.

Additionally, while threaded discussions between CNEs are not feasible on the current platform, finding alternative ways to communicate in a more informal and real-time method could be explored. There is an immediate need identified to begin to look at ways to incorporate more work/life balance activities for the CNEs at all levels, and for the RPCS regional staff. Based on results of the survey, the regional chief nurse designs activities to take place quarterly that combine business and fun. Recently there was a business meeting over the holidays where the morning was spent on meeting content and initiatives and the afternoon was spent making succulent planter boxes together as a team. In Spring, the regional CNE is having a retreat at a seaside resort for the CNEs where they will work on important upcoming strategies in RPCS, but will still make time for an art activity, a bonfire, and networking opportunities as ways to increase the joy people feel at work.

While there is recent data on chief executive officer turnover, there is an existing gap in the literature since 2010 and earlier on nurse executive turnover (American College of Healthcare Executives, 2017). There is also a scarcity of recent statistics on the impact of a CNE departure on hospital operations, staff nurse satisfaction, and progression in safety, quality, and care experience outcomes in a hospital. There is an opportunity for nurse researchers to perform additional studies on these important nurse executive topics.

Section VI. Next Steps

The RPCS Chief Nurse Mentoring Program foundation was overall a successful endeavor that remains an active initiative. The barriers of the influenza season and CNA bargaining did slow progression as these events were more protracted than originally anticipated. In addition, the threatened changes to the ACA had organization-wide effects of strategic focus on cost-savings initiatives. The RPCS Box is active and utilized consistently by CNEs and their teams. The weekly virtual office hours continue, and content is being developed for 15 minute topic presentations to facilitate attendance. The most frequently requested information is related to CNA bargaining and work stoppage preparation. Once those two threats are eliminated by contract ratification, the topic of labor relations will be relevant as the new contract content and interpretation is shared across the region.

Mentoring moments content in the monthly CNE meetings will begin in May, 2018. Every 6 months there will be a re-survey of the CNEs. The focus of the surveys will be on ease of resource access, topics to cover, and content needed in electronic repository as well as perceptions of connectivity and work/life balance. By July the program for onboarding of new nurse leaders at all levels will be complete and the CNE Liaison will be using half of her FTE to

support enhancing the current mentoring foundation. At that time, a formal mentor matching program will be built and implemented.

Section VII. Other Information

Funding

Funding for this project was incorporated into existing pay structures and employee roles in Kaiser Permanente regional PCS. There was no outside finding of this project.

Section VIII. References

American College of Healthcare Executives (2017). *Hospital CEO Turnover Rate Remains Steady.* Retrieved March 8, 2018 from http://www.besmith.com/trends-and-insights/articles/high-cost-leadership-turnover/.

American Psychological Association (2017). *What is Reslience?* Retrieved March 9, 2018 from www.apa.org/helpcenter/road-resilience.aspx.

Arnold, L., Drenkard, K., Ela, S., Goedken, J., Hamilton, C., Harris, C.,…&White, M. (2006). Strategic positioning for nursing excellence in health systems: Insights from chief nurse executives. *Nursing Administration Quarterly, 30*(1), 11-20.

B.E. Smith (2017). Industry Report: High cost of leadership turnover. Retrieved March 18 from https://www.besmith.com/trends-and-insights/articles/high-cost-leadership-turnover/.

Benner, P. (1982). From novice to expert. *American Journal of Nursing, 82*(3), 402-407.

Cantu, K., & Batcheller, J. A. (2016). On-boarding a new chief nursing officer to lead a Magnet redesignation visit. *Nursing Administration Quarterly, 40*(4), 356-360.

Cline, S. (2015). Nurse leader resilience: Career defining moments. *Nursing Administration Quarterly, 39*(2), 117-122.

Colakoglu, S. N., & Gokus, O. (2015). Mentoring functions' relationship with socialization facets and stages: A conceptual framework. *Journal of Organizational Culture, Communication and Conflict, 19*(2), 1-13.

Crawford, C. L., Omery, A., & Spicer, J. (2017). An integrative review of 21st-century roles, responsibilities, characteristics, and competencies of chief nurse executives: A blueprint for the next generation. *Nursing Administration Quarterly, 41*(4), 297-309.

Davis, A., & Maisano, P. (2016). Patricia Benner: Novice to expert – A concept whose time has come (again). *The Oklahoma Nurse,* 13-15.

Dickerson, P. S. (2012). What is a gap and how do I fill it? *The Journal of Continuing Education in Nursing, 43*(3), 100-101.

DiRenzo, M. S., Weer, C. H., & Linnehan, F. (2013). Protégé career aspirations: The influence of formal e-mentor networks and family-based role models. *Journal of Vocational Behavior, 83*(1), 41-50.

Ellis, B. (2015). Non-response in surveys – NA Problem. Retrieved March 6, 2018 from https://socialoptic.com/2015/6

Fennimore, L., & Wolf, G. (2011). Nurse manager leadership development: Leveraging the evidence and system-level support. *Journal of Nursing Administration, 41*(5), 204-210.

Gooch, P. (2017). *Audits and Standard Work Executive Summary.* Internal document: Oakland, California.

Hooley, T., Hutchinson, J., & Neary, S. (2016). Ensuring quality in online career mentoring. *British Journal of Guidance and Counseling, 44*(1), 26-41.

Hudgins, T. A. (2016). Resilience, job satisfaction, and anticipated turnover in nurse leaders. *Journal of Nursing Management, 24,* 62-69.

Huston, C. (2008). Preparing nurse leaders for 2020. *Journal of Nursing Management, 16,* 905-911.

Institute of Medicine of the National Academies (2004). *Keeping Patients Safe: Transforming the Work Environment of Nurses.* Washington, DC: The National Academies Press.

Jackson, J. P., Clements, P. T., Averill, J. B., & Zimbro, K. (2009). Patterns of knowing: Proposing a theory for nursing leadership. *Nursing Economics, 27*(3), 149-159.

Javed, P., & Wallace, J. (2016). Advancing professional practice in Northern California. *2016 KFH/HP Nursing Report.* Kaiser Permanente: Oakland, CA.

Johnson, M. O., & Gandhi, M. (2015). A mentor training program improves mentoring competency for researchers working with early-career investigators from underrepresented backgrounds. *Advances in Health Science Education, 20,* 683-689.

Jones, C. B., Havens, D. S., & Thompson, P. A. (2009). Chief nursing officer turnover and the crisis brewing. *The Journal of Nursing Administration, 39*(6), 285-292.

Jones, P., Polanich, S., Steaban, R., Fesitritzer, N., & Poe, T. (2017). Transformational leadership: The chief nursing officer role in leading quality and patient safety. *Journal for Healthcare Quality, 39*(3), 186-190.

Kaiser Permanente (2016). *National Workforce Planning*. Internal Document: Oakland, California.

Kaiser Permanente (2017). *Contingency Workgroup*. Internal Document: Oakland, California.

Kaiser Permanente (2017). New Landscape of Health. Retrieved March 3, 2017 from http://lookinside.kaiserpermanente.org/new-landscape-of-health-care/.

Kaiser Permanente (2018). *Budget Planning Tool*. Internal Document: Oakland, California.

Klinge, C. M. (2015). A conceptual framework for mentoring in a learning organization. *Adult Learning, 26*(4), 160-166.

Kouzes, J., & Posner, B. (2007). *Leadership: The Challenge*. Jossey-Bass: San Francisco.

Kouzes, J., & Posner, B. (2009). The five practices of exemplary leadership. In Billsberr, J. (Ed) *Discovering Leadership.* Palgrave MacMillan: Basingstoke, Hampshire, England.

Lemire, J. A. (2005). Preparing nurse leaders: A leadership education model. In H.R. Feldman and M.J. Greenberg (Eds.), *Educating Nurses for Leadership* (p 3-15). New York: Springer Publishing.

Luanaigh, P., & Hughes, F. (2016). The nurse executive role in quality and high performing health services. *Journal of Nursing Management, 24,* 132-136.

Martin, E., & Warshawsky, N. (2017). Guiding principles for creating value and meaning for the next generation of nurse leaders. *Journal of Nursing Administration, 47*(9), 418-420.

McCloughlen, A., O'Brien, L., & Jackson, D. (2010). More than vision: Imagination as an elemental characteristic of being a nurse leader-mentor, *Advances in Nursing Science, 33,*(4), 285-296.

McCloughen, A., O'Brien, L., & Jackson, D. (2011). Nurse leader mentor as a mode of being: Findings from an Australian hermeneutic phenomenological study. *Journal of Nursing Scholarship, 43*(1), 97-104.

Merriam Webster (n.d.). Resilience. Retrieved March 6, 2017 from https://www.merriam-webster.com/dictionary/resilience.

Mezirow, J. (1994). Understanding transformation theory. *Adult Education Quarterly, 33,* 161-173.

Mueller, K., Voelke, M. C., & Hattrup, K. (2011). On the relationship between job satisfaction and non-response in employee attitude surveys: A longitudinal field study. *Journal of Occupational and Organizational Psychology, 84,* 780-798.

Polit, D. F., & Beck, C. T. (2014). *Essentials of Nursing Research Appraising Evidence for Nursing Practice.* Wolters Kluwer/Lippincott Williams & Wilkins: Philadelphia.

Prestia, A. S. (2015). Chief nursing officer sustainment: A phenomenological inquiry. *Journal of Nursing Administration, 45*(11), 575-581.

Prestia, A. S., Sherman, R. O., & Demezier, C. (2017). Chief nursing officers' experience with moral distress. *47*(2), 101-107.

Quatara, B., Rea, K., Wilkins, K., & Facteau, L. (2017). Partnering to improve outcomes: The nurse executive and the clinical nurse specialist. *Nurse Leader, 15*(1), 61-64.

Shirey, M. R. (2007). Competencies and tips for effective leadership: From novice to expert. *Journal of Nursing Administration, 37*(4), 167-170.

Somner, C. A., Markopoulis, P., & Goggins, S.L. (2013). Mentoring master's level students: Drawing upon the wisdom of Athena as Mentor in Homer's Odyssey. *Journal of Poetry Therapy, 26*(1), 1-12.

St. John, B. (2017). *We Call This Micro-Resilience*. Retrieved March 13, 2018 from http://microresilienceprogram.com/.

Tizer, J. L., Shirley, M. R., & Hauck, S. (2014). A nurse manager succession planning model with associated empirical outcomes. *Journal of Nursing Administration, 44*(1), 167-170.

Trepanier, S., & Crenshaw, J.T. (2013). Succession planning: a call to action for nurse executives. *Journal of Nursing Administration, 21*, 980-985.

Valiga, T. M., & Grossman, S. (2007). Leadership and followership. In R.A.P. Jones (Ed.), *Nursing Leadership and Management. Theories, Processes, and Practice,* (p 3-12). Philadelphia: F.A. Davis Company.

Vinales, J. J. (2015). The mentor as a role model and the importance of belongingness. *British Journal of Nursing, 24*(10), 532-535.

Williams, R. L., McDowell, J. B., & Kautz, D.D. (2011). A caring leadership model for nursing's future. *International Journal for Human Caring, 15*(1), 31-35.

Waxman, K.T., Delucas, C. (2014). Succession planning: Using simulation to develop nurse leaders for the future. *Nurse Leader, 12*(5), 24-28.

Wright, P. (2017). Does a CEO's departure trigger a crisis for a CNE? *Nursing Administration Quarterly, 41*(3), 233-236.

Wroten, S. J., & Waite, R. (2009). A call to action Mentoring within the nursing profession – A wonderful gift to give and share. *Association of Black Nursing Faculty*, Fall, 106-108.

Zachary, L. J. (2005). *Creating A Mentoring Culture.* Jossey-Bass: San Francisco.

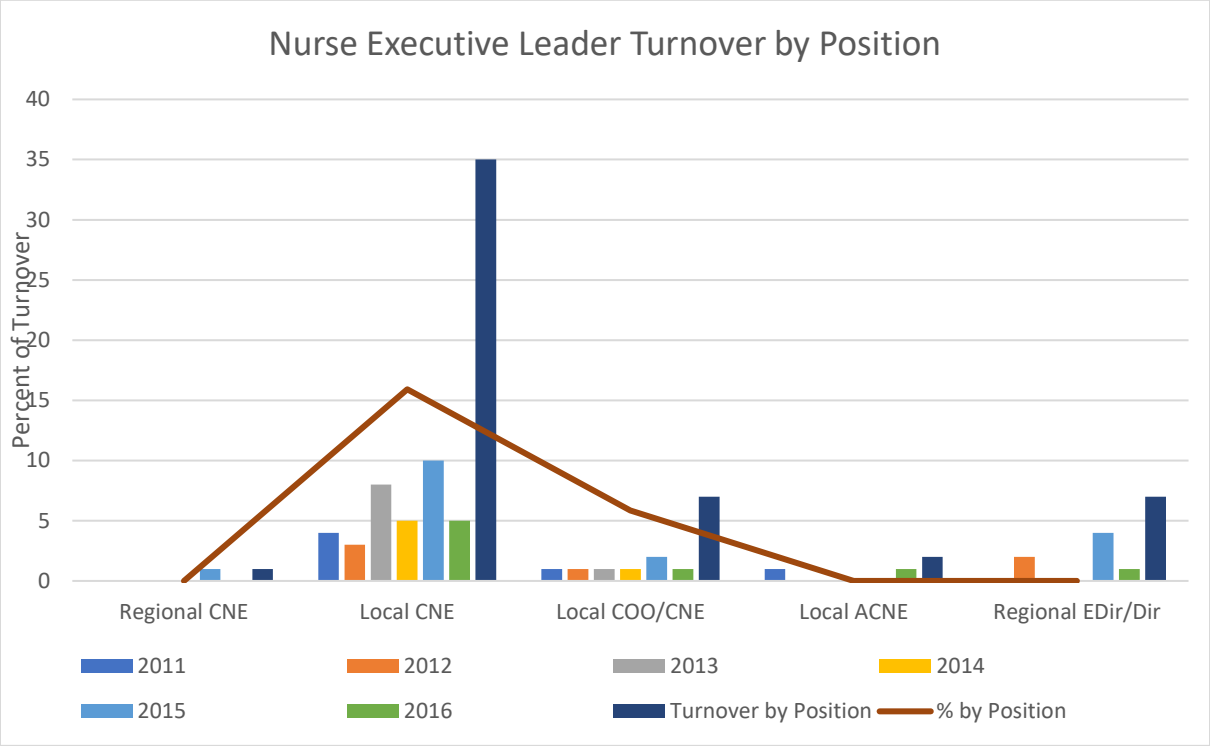
Zachary, L. J. (2012). *The Mentor's Guide.* Jossey-Bass: San Francisco.

Zerwas, C., & von Korflesch, H.F.O. (2016). A conceptual model of entrepreneurial reputation from a venture capitalist's perspective. *The International Journal of Entrepreneurship and Innovation, 17*(3), 143-154.

Section VIII. Appendices

Appendix A

Nurse Executive Leader Turnover by Position



Appendix B

Assessing the Model for Change (Readiness, Opportunity and Support)

Element	KP NCAL CNE Peer Group
CNE Peer Group readiness for the Support and Mentorship Framework	1. Recovering from turnover crisis in 2015 2. *First time in 3 years all CNE roles are filled with permanent (not interim) staff 3. *All regional executive positions are filled *all of these are fluid realities
Existing Opportunities to Engage the CNE Peer Group	1. Existing relationship between mentoring program author and CNEs (former CNE) 2. Monthly Peer Group 3. Monthly CNE Phone Call 4. Quarterly medical center site visits by mentoring program author or designee
Structures/Platforms that exist to facilitate the Support and Mentorship Framework	1. Existing RPCS Box platform for the CNEs 2. Existing CNE orientation (out of scope) – *other workflow in process* 3. Regional PCS resources available/assigned to mentoring program

Zachary (2005)

Appendix C

Evidence Evaluation Table

Citation	Design	Sample/Setting	Results/Outcomes	John Hopkins Evidence-Based Practice Appraisal Tool
Cantu, K., & Batcheller, J.A. (2016). On-boarding a new chief nursing officer to lead a Magnet redesignation visit. *Nursing Administration Quarterly, 40*(4), 356-360.	Case study of how one organization enculturated a new chief nursing officer (CNO) to lead the hospital through a Magnet re-designation.	A facility that had received its initial Magnet designation in 2010, with re-designation application submission in 2014. Size and location of facility not disclosed.	A successful Magnet re-designation survey 80 days after the new CNO started, with commentary by the surveyors on the new CNO's visibility, engagement, and knowledge of staff and processes. The value of the former CNO mentoring the new CNO was useful to demonstrate the value of mentoring.	Level V/B – Expert Opinion
Crawford, C.L., Omery, A., & Spicer, J. (2017). An integrative review of 21st-century roles, responsibilities, characteristics, and competencies of chief nurse executives: A blueprint for the next generation. *Nursing Administration Quarterly, 41*(4), 297-309.	Integrative review to examine the available evidence outlining the job functions and responsibilities of chief nurse executives (CNEs) and chief nursing officers (CNOs).	An integrative evidence review of English language publications between 2004 – 2015. The search yielded 32 relevant articles, 15 articles were eliminated, and the remaining 17 were used in the review.	Pertinent to the mentoring program for new CNEs, the evidence-based recommendations: • Create a nurturing mentoring culture • Targeted role-modeling • Support system within organization • Create a community of CNEs	Level IV/B – Summative Review
Fennimore, L. & Wolf, G. (2011). Nurse manager leadership development: Leveraging the evidence	Summative review to identify key competencies essential for nurse managers and description	University of Pittsburgh Medical Center, integrated academic health system of 20 hospitals and outpatient	Incorporating mentoring strategies with self-assessment opportunities assists in growing the	Level IV/A - Organizational

and system-level support. *Journal of Nursing Administration, 41*(5), 204-210.	of a pilot program "UPMC Leadership Development for Nursing Middle Managers program.	areas, employing 10,000 nurses.	depth and breadth of leadership resiliency and effectiveness and reduce turnover and improve quality.	
Hudgins, T.A. (2016). Resilience, job satisfaction, and anticipated turnover in nurse leaders. *Journal of Nursing Management, 24,* 62-69.	Quantitative study designed to identify the relational aspects between resilience, job satisfaction and retention in nurse leader roles.	Convenience sampling sent to 495 nurse leaders at multiple levels in the organization in a multi-hospital system in southwestern Virgina: • Bedside Leaders • Department Leaders • Service Line Leaders • Organizational Leaders 89 completed surveys were returned.	Pertinent to the mentoring program for new CNEs, the evidence-based implications for correlation between reliance, job satisfaction, and retention. • Retention leads to stable nursing teams at all levels of the organization • Incumbent nurse leaders should first identify their own resilience-enhancing tools • Resilient nurse leaders are more apt to stay in their position.	Level III/B – organizational study with reasonably consistent recommendations and impressive correlation between factors. Limitations identified were study dissemination via corporate email – a high number of "decline to answer" in the demographic area could indicate nurse leaders were concerned about anonymity of the survey.
Jones, C.B., Havens, D.S., & Thompson, P.A. (2009). Chief nursing officer turnover and the crisis brewing. *The Journal of Nursing Administration, 39*(6), 285-292.	An American Organization of Nurse Executives study to examine how turnover at the level of the chief nurse executive impacts the perceptions of nurses in other role in the organization.	An online survey sent to all CNOs – members of AONE and non-members who were asked to forward the survey to staff nurses and nurse managers in their reporting structure. 1277 frontline and management nurses across the United States responded to the survey.	CNOs are critical to operations, yet when a chief nurse leaves – even though the staff nurse experiences a sense of loss – they are resilient. The impact of a CNO departures is felt throughout the organization.	Level V/B – Research Limitations include not being able to track participants, or assure that participants did not take the survey more than once.

Luanaigh, P., & Hughes, F. (2016). The nurse executive role in quality and high performing health services. *Journal of Nursing Management, 24,* 132-136.	Commentary paper to identify key attributes of the role of CNE, and how these elements contribute to the success of healthcare organizations in the realms of quality and performance.	Literature review, search criteria or returned results not indicated.	Affirms the value of the CNE to healthcare organizations, and vital to efficient, safe, and quality care.	Level V/C – Undefined methods, although there are many studies included. To be fair – this was presented as commentary only.
McCloughen, A., O'Brien, L., & Jackson, D. (2011). Nurse leader mentor as a mode of being: Findings from an Australian hermeneutic phenomenological study. *Journal of Nursing Scholarship, 43*(1), 97-104.	Hermeneutic phenomenology study to explore what experiences and information that Australia nurses apply to their mentoring relationships.	A purposive sample of 13 Australian nurse leaders and their subjective experiences with mentoring.	Individuals are drawn to each other through shared interests or values that are of their own making of the individuals in the relationship – classic traits in both formal and informal mentoring relationships.	Level III/A
Prestia, A.S. (2015). Chief nursing officer sustainment: A phenomenological inquiry. *Journal of Nursing Administration, 45*(11), 575-581.	Phenomenological study to discover how CNOs sustain themselves through the challenges of being an executive nurse leader.	Twenty CNOs were interviewed on the lived experience of sustainment in their executive roles.	Six themes emerged: • Love of the profession of nursing • Broad impact on care • Self-reflection • Managing conflict • Work/life balance • Supportive leaders Study also affirmed through verbatim comments that CNOs thrive when they mentor others. This supports the goal of the mentoring program to engage incumbent CNEs. Study	Level III/A – Organizational.

			also supports the need for resilience of the CNE – something else a mentor can help them achieve.	
Tizer, J.L., Shirley, M.R., & Hauck, S. (2014). A nurse manager succession planning model with associated empirical outcomes. *Journal of Nursing Administration, 44*(1), 167-170.	Systematic Literature Review – Summative Review	English language articles published between 2007 – 2013 in peer reviewed journals. 156 articles were reviewed.	Programs designed to enrich knowledge through workshops, mentoring, and group activities increase leadership confidence and competencies in executive roles	Level IV/B
Wroten, S.J., & Waite, R. (2009). A call to action Mentoring within the nursing profession – A wonderful gift to give and share. *Association of Black Nursing Faculty*, Fall, 106-108.	Commentary/Call to Action with literature review.	Not specified.	Incumbent CNEs can benefit from their contribution to the growth and development of newer CNEs to fully realize their own potential as leaders, and diversity in leadership is often the result of mentoring.	Level V/B

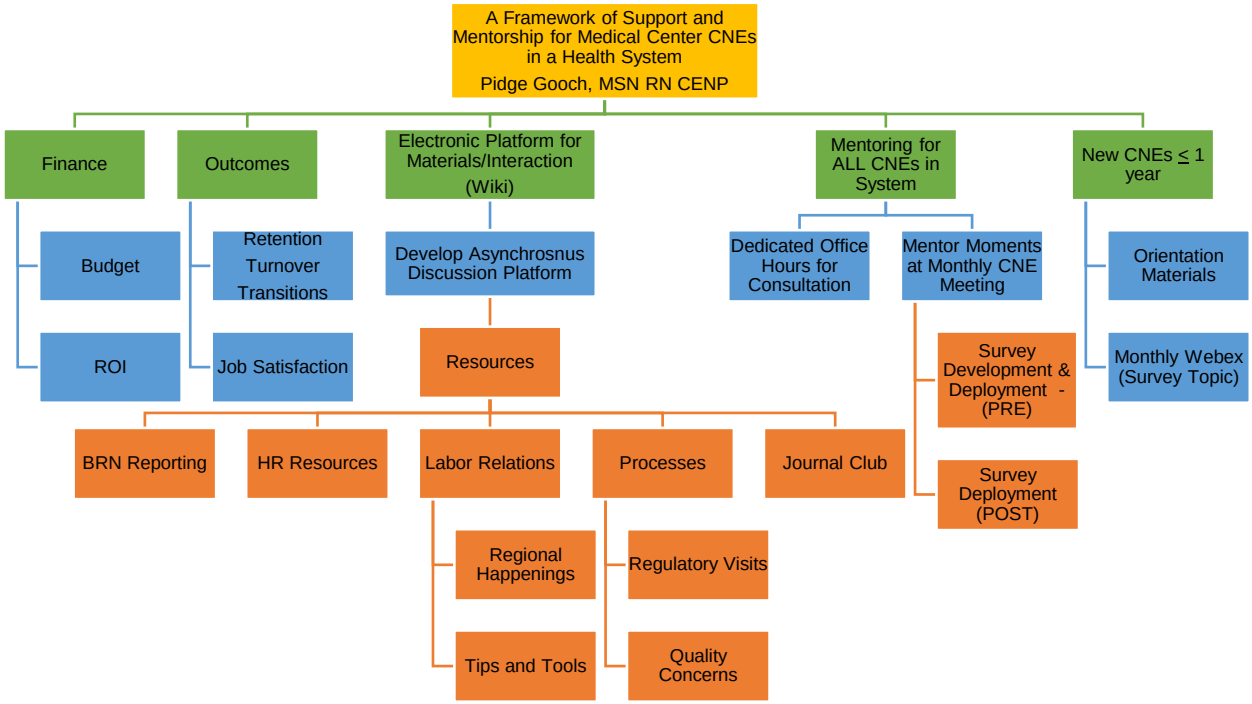
Appendix D

Caring Leadership Progression Model

Theoretical Element	Novice (<6 months)	Advanced Beginner (6 months – 1 year	Competent (1 – 3 years)	Proficient (3 – 5 years)	Expert >5 years
Model the Way	Exposed to all levels of CNEs provide role modeling	Linked with Competent CNEs to provide role modeling	Linked with Proficient CNEs to provide role modeling	Linked with Expert CNEs to provide role modeling	Linked with Regional CNE to provide role modeling
Inspire a Shared Vision	Introduced to the RPCS Vision	Assimilates Regional PCS Vision to Local PCS Vision	Introduces Local PCS Vision to local medical center(s)	Refines Local PCS Vision to align with operational strategies	Leads efforts to refine Regional PCS Vision
Challenge the Process	Brings new perceptions to old standards in organization	Assimilates best practices outside of organization into local medical center	Introduces best practices to local and regional PCS	Refines local and regional best practices internal/external to organization	Participates in spread of local and regional best practices to National PCS
Enable Others to Act	Is open to mentoring and orientation process	Is open to mentoring, and offers an environment of acceptance to Novice CNE and local medical center PCS leadership	Provides encouragement and mentoring in an open and accepting environment to the Advanced Beginner CNE. Begins succession planning at local medical center.	Provides encouragement and mentoring in an open and accepting environment to the Competent CNE. Actively engages in succession planning activities at local medical center.	Provides encouragement and mentoring in an open and accepting environment to the Proficient CNE. Participates in Regional and Local Succession Planning in collaboration with Regional CNE
Encourage the Heart	Practices kindness and patience to self and others	Inspires an environment of trust with local and regional colleagues	Inspires their local leaders in leadership aspirations	Engages their local leaders in activities that lead to succession planning options	Supports the Regional CNE as sounding board and advisor

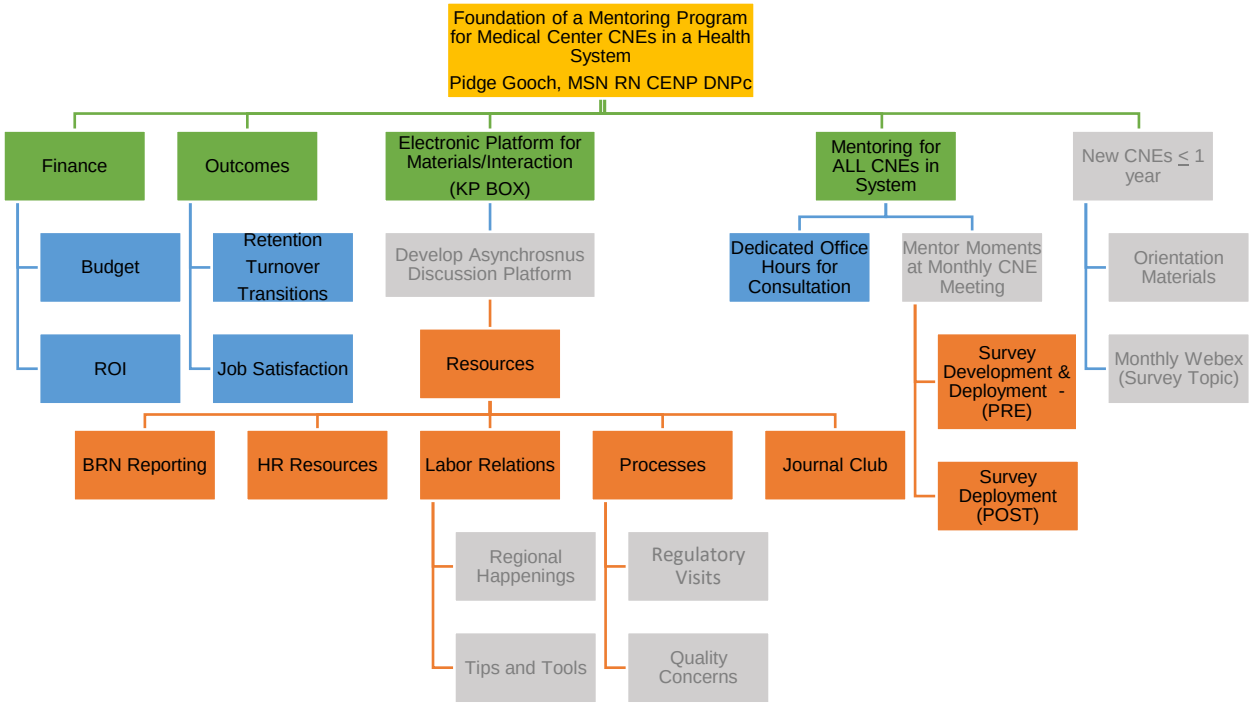
Appendix E

Proposed Work Breakdown Structure – April 2017



Appendix F

Revised Work Breakdown Structure – January 2018



Boxes in grayscale are future possible features of the program

Appendix G

SWOT Analysis

Strengths	**Weaknesses**
• Executive sponsorship commitment to process • Time allocated to Program Leader to develop resources/mentor CNEs • RPCS Box is extremely user-friendly • Internal subject matter experts administering RPCS Box	• RPCS Box is new technology to most – resistance to learn something new at a critical time • Inherent non-standard workflows across the 21 medical centers • Inconsistent forms used throughout the region
Opportunities	**Threats**
• Teachable moment – new leadership culture • New CNEs engaged in enthusiastic learning • Leverage use of RPCS Box in crisis mode to increase standardization of forms/processes and workflows • Use RPCS Box for mentoring program	• Cyber-security/ransomware with RPCS box hosted on outside server • Critical/sensitive information

Appendix H

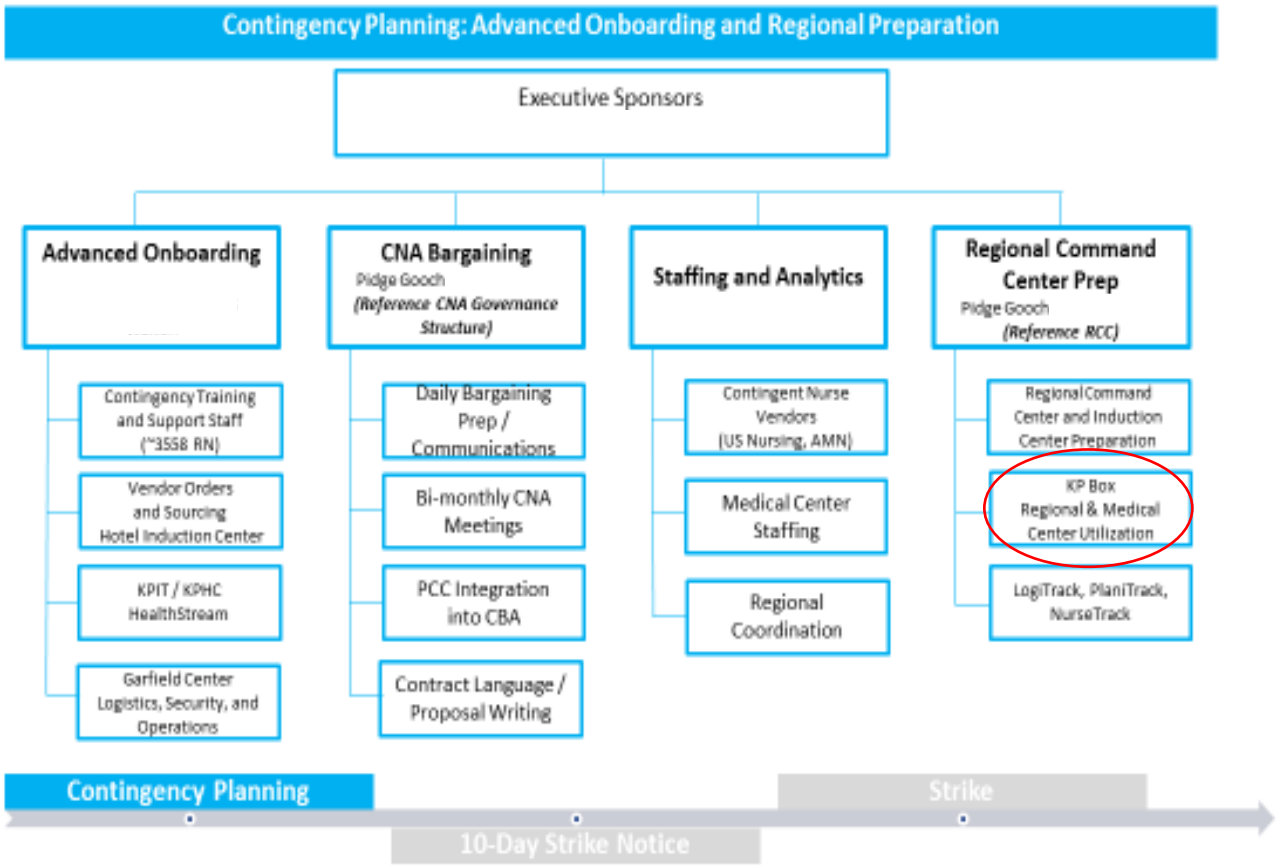
Regional Patient Care Services Management Relations Model of Reputation

<table>
<tr><td>Market/Industry
Existing agency solid customer base
Market ripe for innovation
Volatile period in healthcare</td><td>Product/Services
Timely information
Existing framework (RPCS Box Format)
Reputational Credibility</td></tr>
<tr><td>Innovation
Highly innovative
Protected Sensitive Information (labor relations)
Leveraging technology advances since 2014</td><td>Finance
Low cost
Most costs absorbed into other roles</td></tr>
<tr><td colspan="2">Balanced Team</td></tr>
<tr><td>Personality of Team
Motivated
Engaged
Exciting Communicators
Resilient
Risk-takers</td><td>Experience
Combined 75 years of healthcare experience
Executive leadership experience
Relevant management experience with bargaining and contingency planning</td></tr>
</table>

(Zerwas & von Korflesch, 2016, p. 150)

Appendix I

Example - KP NCAL Contingency Planning/Regional Preparation Organizational Chart

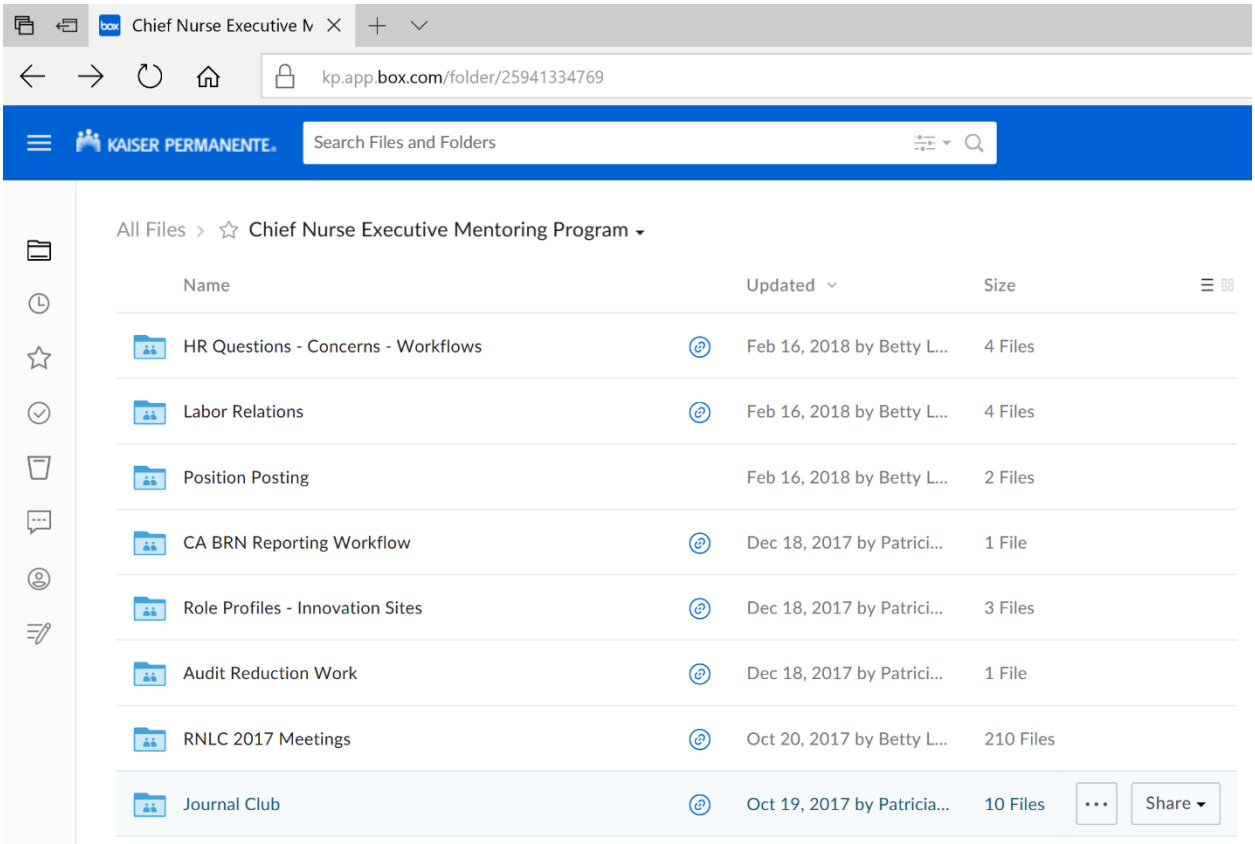


KAISER PERMANENTE®

Kaiser Permanente (2017)

Appendix J

Screenshot of RPCS Box Contents



Appendix K

Mentoring for Chief Nurse Executives Budget/ROI Considerations

	Executive Consultant	Admin Support	KP Box Administrators	Executive Coach	Total Salary Costs
Annual Total Hours of Mentoring Work	80	40	120	6	
Avg Salary/Costs	$4,160	$1,540	$4,320	$1,800	**$11,820**

Estimated Cost Avoidance Calculation

CNE Turnover	Average CNE Salary*	Replacement Costs (1.5 X Salary)**	Potential Cost Avoidance***
1	$239,000	$385,500	$119,500
2	$478,000	$717,000	$239,000

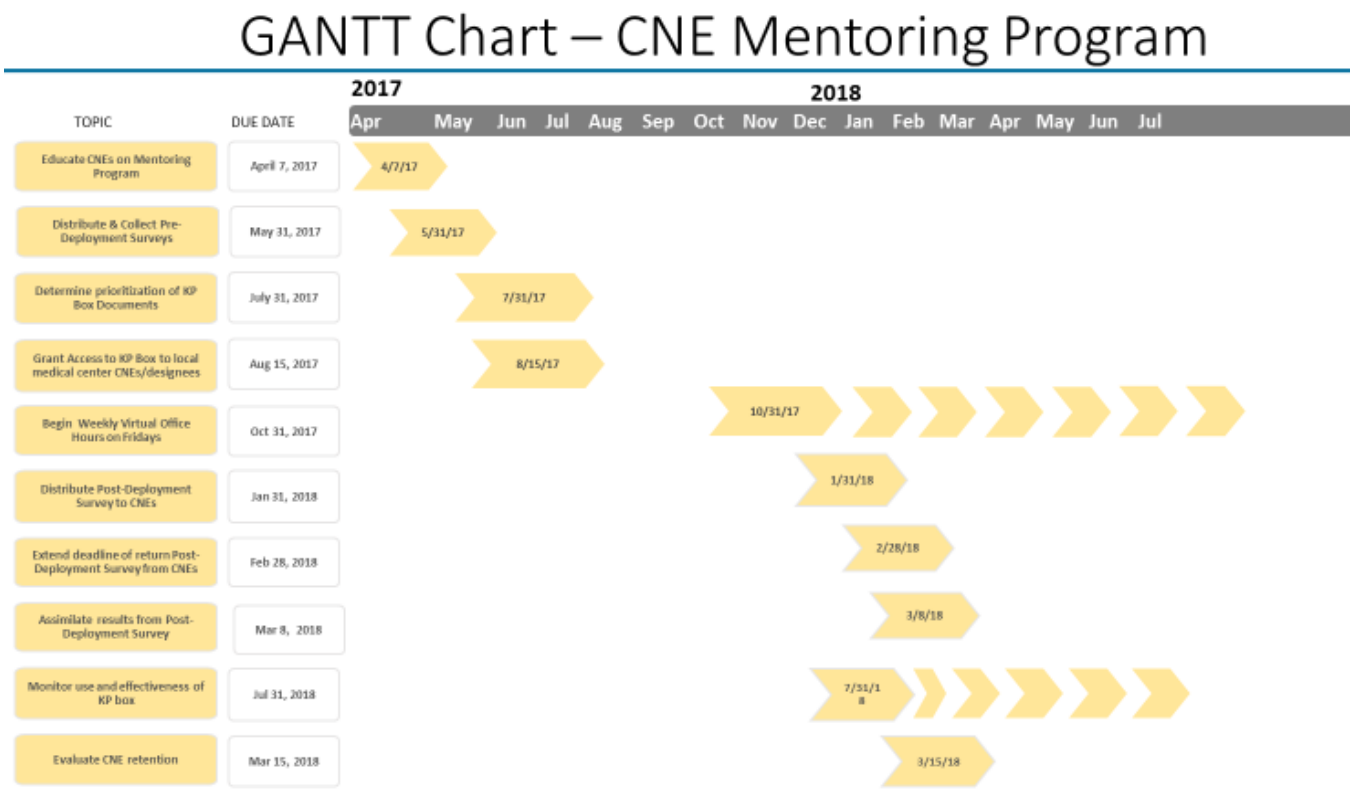
Cost Benefit – Cost Avoidance

	2017	2018	2018
Program Costs	$11,820	$11,820	$11,820
Cost Benefit	Turnover Continues at current pace	Improve Retention by 1 CNE	Improve Retention by 2 CNEs
Cost Avoidance R/T Turnover	0	$119,500	239,000
Cost Avoidance R/T Termination of Outside Exec. Coach	0	$98,000	$98,000
ROI	($11,820)	**$205,680**	**$325,180**

*Average CNE salary is estimated at $239,000 annually: Source KP Workforce Planning (2016)
**CNE Replacement Cost is a calculation of 150% of current salary: Source Arnold, et al., (2006)
***Cost Avoidance is savings related to turnover and not meant to represent revenue from program

Appendix L

GANTT Chart



Appendix M

Support and Mentoring Framework Pre-Deployment Survey

Our organization is looking at establishing a framework that offers support and mentoring to CNEs at all levels of proficiency in the role. The purpose of this survey is to establish a baseline of the population and to identify key areas of focus for content and program attributes. Your help is critical to evaluate interest in this program. Thank you!

1. Years as at the level of a CNE – any organization
    a. Less than 6 months
    b. Less than 1 year
    c. 1 to 3 years
    d. 3 to 5 years
    e. Greater than 5 years
2. Years at the level of a CNE ***specifically at XX, Northern California***
    a. Less than 6 months
    b. Less than 1 year
    c. 1 to 3 years
    d. 3 to 5 years
    e. Greater than 5 years
3. If mentoring became available, would you participate?
    a. Yes, as a Mentor
    b. Yes, as a Mentee
    c. Yes, as both a Mentor and a Mentee
    d. No, not interested
4. If a program of support and mentoring for CNEs became available, what areas might you seek guidance? (choose all that are applicable)
    a. Discussion Board Thread with RPCS CNE Colleagues
    b. Labor Relations electronic resources
    c. Terminations electronic resources
    d. Board Reporting electronic resources
    e. Staffing Resources (electronic)
    f. Regulatory Visits/Sentinel/Quality events electronic resources
    g. Journal Club via electronic repository of interesting articles
    h. Mentoring Meetings – one hour per month (via webex or in-person)
    i. Standing, weekly dedicated office hours of regional Executive Director of PCS Ops

For the following questions, please use a scale from 0 to 5:

0 = not at all 1 = rarely 2 = occasionally 3 = sometimes 4 = regularly 5 = always

to describe your feelings related to the following questions:

5. I know where to ***easily*** find forms, processes, and information as it relates to labor relations, regulatory agency visits, quality concerns, terminations, and BRN reporting workflows
    0 1 2 3 4 5
6. I have a resource I can connect with to help me feel engaged and connected to my role as CNE
    0 1 2 3 4 5
7. I feel I have achieved balance between my work and personal life commitments
    0 1 2 3 4 5
8. I feel connected to my CNE colleagues across RPCS
    0 1 2 3 4 5
9. I feel regional leadership support is readily available to meet the needs of the medical center CNEs
    0 1 2 3 4 5
10. I am very satisfied with my role as CNE at KP NCAL
    0 1 2 3 4 5

Appendix N

Support and Mentoring Framework Post-Deployment Survey

In the last several months, our organization began looking at establishing a framework that offers support and mentoring to CNEs at all levels of proficiency in the role. The purpose of this survey is to check-in and see what the early findings from our interventions have accomplished. Your help is critical to evaluate the efficacy of this program. In consideration of time constraints on the CNE, this survey has been designed with only 10 questions. Thank you, in advance, for your participation!

1. Years as at the level of a CNE – any organization
    a. Less than 6 months
    b. Less than 1 year
    c. 1 to 3 years
    d. 3 to 5 years
    e. Greater than 5 years

2. Years at the level of a CNE ***specifically at XX, Northern California***
    a. Less than 6 months
    b. Less than 1 year
    c. 1 to 3 years
    d. 3 to 5 years
    e. Greater than 5 years

3. If a formal mentoring program became available, would you participate?
    a. Yes, as a Mentor
    b. Yes, as a Mentee
    c. Yes, as both a Mentor and a Mentee
    d. No, not interested

4. Part of the program of support and mentoring for CNEs we offered several resources. Please rate how helpful these resources were to you over the last several months.

Please use a scale from 0 to 5:
0 = not at all 1 = rarely 2 = occasionally 3 = sometimes 4 = regularly 5 = always
to describe your frequency in accessing the resources:

    a. Labor Relations electronic resources – including work stoppage planning documents
    0 1 2 3 4 5
    b. Terminations electronic resources
    0 1 2 3 4 5
    c. Board Reporting electronic resources
    0 1 2 3 4 5
    d. Staffing Resources (electronic)
    0 1 2 3 4 5
    e. Journal Club via electronic repository of interesting articles
    0 1 2 3 4 5
    f. Dedicated office hours of regional Executive Director of PCS Ops (Pidge Gooch) via bridge line (informal/drop-in)
    0 1 2 3 4 5

Appendix N (continued)

Please use a scale from 0 to 5:
0 = not at all 1 = rarely 2 = occasionally 3 = sometimes 4 = regularly 5 = always
to describe your feelings related to the following questions:

5. I know where to ***easily*** find online forms, processes, and information as it relates to labor relations, HR Questions, terminations, and BRN reporting workflows
   0 1 2 3 4 5
6. I have a resource I can connect with to help me feel engaged and connected to my role as CNE
   0 1 2 3 4 5
7. I feel I have achieved balance between my work and personal life commitments
   0 1 2 3 4 5
8. I feel connected to my CNE colleagues across RPCS
   0 1 2 3 4 5
9. I feel regional leadership support is readily available to meet the needs of the medical center CNEs
   0 1 2 3 4 5
10. I am very satisfied with my role as CNE at RPCS
    0 1 2 3 4 5

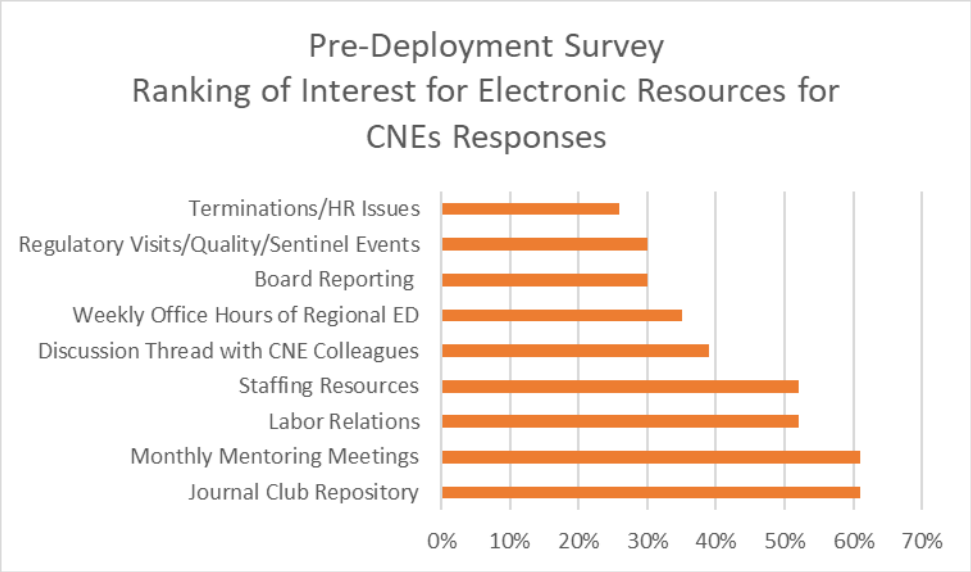
Free Text Question:

Please provide comments related to your experience with any of the foundational elements of the mentoring program that have started – including the RPCS Box resource and standing meetings with Pidge Gooch and Regional Subject Matter Experts and/or where you would like to see this program go in the future?

Your cooperation is deeply appreciated – thank you!

Appendix O

Ranking of Interests for Electronic Resources (Pre-Deployment)



Appendix P

Kaiser Permanente Research Determination

Kaiser Foundation Research Institute

Kaiser Permanente
Research
Transforming the future of health

Subject/Title: RDO-KPNC17-53; Support and Mentorship Framework for Chief Nurse Executives in a Health System

Date: 8/21/2017

Dear Patricia Gooch;

Please see below determination outcome.

As the Research Determination Official (RDO) for the Kaiser Permanente Northern California region, I have reviewed the documents submitted for the above referenced project. The project does not meet the regulatory definition of research involving human subjects as noted here:

☒ **Not Research**
The activity does not meet the regulatory definition of **research** per 45 CFR 46.102(d): A systemic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge.

☐ **Not Human Subject Research**
The activity does not meet the regulatory definition of **research involving human subjects** per 45 CFR 46.102(f): Human subjects means a living individual about whom an investigator conducting research obtains (1) data through intervention or interaction with the individual, or (2) identifiable private information.

Therefore, the project is not required to be reviewed by a KP Institutional Review Board (IRB). This determination is based on the information provided. If the scope or nature of the project changes in a manner that could impact this review, please resubmit for a new determination. Also, you are responsible for keeping a copy of this determination letter in your project files as it may be necessary to demonstrate that your project was properly reviewed.

Provide this approval letter to the Physician in Charge (PIC), your Area Manager, and Chief of Service, to determine whether additional approvals are needed.

Sincerely,

Eric Garcia
National Research Compliance Officer
Director, National Compliance in Research Support Program
Kaiser Foundation Research Institute
1800 Harrison Street
Suite 1600
Oakland, CA 94612
510-625-2397 (telephone)
510-625-2330 (fax)
Eric.F.Garcia@kp.org

Appendix Q

DNP Project Approval Form: Statement of Determination

Student Name: Patricia "Pidge" Gooch, MSN RN CENP

Title of Project:

Nursing Innovation: Virtual Mentor and Support for Seasoned, New, and Interim Chief Nurse Executives practicing in the Northern California Region of Kaiser Permanente

Brief Description of Project:

Over the last three years in Kaiser Permanente, the Northern California Region has experienced a large amount of turnover in Chief Nurse Executives in the 21 medical centers. The large and dynamic nature of the highly-matrixed organization can be challenging for a CNE new to the system, new to the role of CNE, in an interim role (stretch assignment), or new to both the role and the organization. However, with the aging workforce, I believe the population of experienced CNEs is dwindling, and we have to prepare for a season of novice CNEs in unprecedented times in our nation's healthcare legacy.

Historically there has been no formal and consistent orientation to the role of Chief Nurse Executive in the Northern California Region of Kaiser Permanente. Often, the CNE is learning in a trial-by-fire modality. While altering the current orientation for CNEs is out of scope for this project, there are many CNEs that are fairly new to their role (less than two years) who could benefit from a virtual mentoring experience where they could access information easily and on their own time, provide a resource to their directors who cover for them when they are out of the building, and also provide an opportunity for personal engagement with a regional leader.

A) Aim Statement:

By December 1, 2017 an intranet site will be fully operational and CNEs will report an increase in job satisfaction, confidence in role, accessibility of information, and perception of regional support and voluntary CNE turnover will decrease by 50% over prior year. (Historical data pending – AIM statement goal may change – this is working AIM).

Appendix Q (continued)

B) Description of Intervention:

The project will provide both an electronic platform/resource accessible through the Kaiser Permanente intranet where all CNEs in Northern California will be able to access forms, toolkits for initiatives, format to spread innovation and best practices, include a 'Frequently Asked Questions' (FAQs) section, message boards and suggested workflows for events such as campus union activity, terminations, and regulatory visits in an informal and engaging virtual environment. In addition, the role of a regional mentor will be defined and operationalized through this author's experience in that role providing personal mentoring and connection to the CNEs as well as administering the web page.

C) How will this intervention change practice?

This intervention will assist the CNEs to feel supported, have access to information in a one-step virtual spot. They will no longer have to send out group emails and hope for a response from someone, or expose themselves to being judged for their lack of knowledge. I envision the page as fun and interactive – a welcome relief in a busy day where the CNE can also access necessary information and feel connected. The regional mentoring that will complement the online environment will also assist in facilitating

confidence and engagement in their role of CNE with positive feedback

and investment coaching.

D) Outcome Measurements:

1. Decrease in Voluntary Turnover for CNEs (Amount TBD)
2. Increase in Job Satisfaction
3. Increase in perception of regional support in CNE role
4. Increase in perception of information accessibility

To qualify as an Evidence-based Change in Practice Project, rather than a Research Project, the criteria outlined in federal guidelines will be used: (http://answers.hhs.gov/ohrp/categories/1569)

X This project meets the guidelines for an Evidence-based Change in Practice Project as outlined in the Project Checklist (attached). Student may proceed with implementation.

☐ This project involves research with human subjects and must be submitted for IRB approval

Appendix Q (continued)

EVIDENCE-BASED CHANGE OF PRACTICE PROJECT CHECKLIST *

Instructions: Answer YES or NO to each of the following statements:

Project Title:	**YES**	**NO**
The aim of the project is to improve the process or delivery of care with established/ accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.	X	
The specific aim is to improve performance on a specific service or program and **is a part of usual care**. ALL participants will receive standard of care.	X	
The project is **NOT** designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control). The project does **NOT** follow a protocol that overrides clinical decision-making.	X	
The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does **NOT** develop paradigms or untested methods or new untested standards.	X	
The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does **NOT** seek to test an intervention that is beyond current science and experience.	X	
The project is conducted by staff where the project will take place and involves staff who are working at an agency that has an agreement with USF SONHP.	X	
The project has **NO** funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.	X	
The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., **not** a personal research project that is dependent upon the voluntary participation of colleagues, students and/ or patients.	X	
If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section: *"This project was undertaken as an Evidence- based change of practice project at X hospital or agency and as such was not formally supervised by the Institutional Review Board."*	X	

ANSWER KEY: If the answer to **ALL** of these items is yes, the project can be considered an Evidence-based activity that does NOT meet the definition of research. **IRB review is not required. Keep a copy of this checklist in your files.** If the answer to ANY of these questions is **NO**, you must submit for IRB approval.

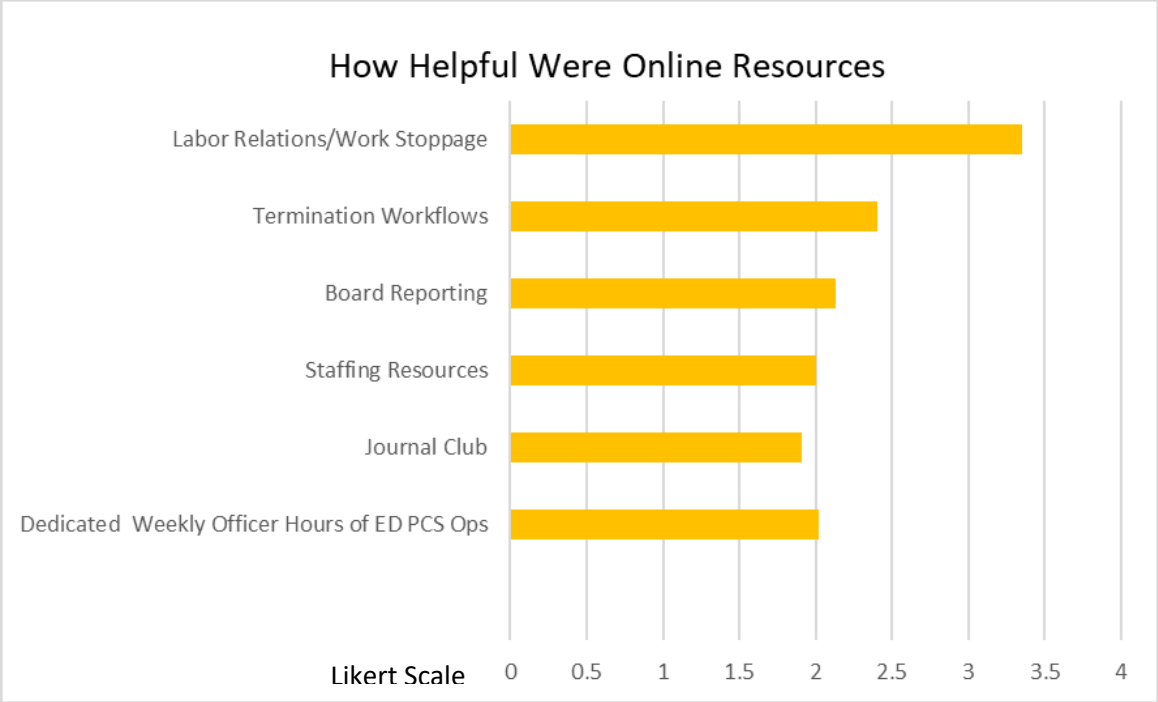
*Adapted with permission of Elizabeth L. Hohmann, MD, Director and Chair, Partners Human Research Committee, Partners Health System, Boston, MA

STUDENT NAME (Please print): Patricia G. Gooch
Signature of Student: Patricia G. Gooch (electronic signature)

SUPERVISING FACULTY MEMBER (CHAIR) NAME (Please print): KT Waxman,
Signature of Supervising Faculty Member (Chair): _____

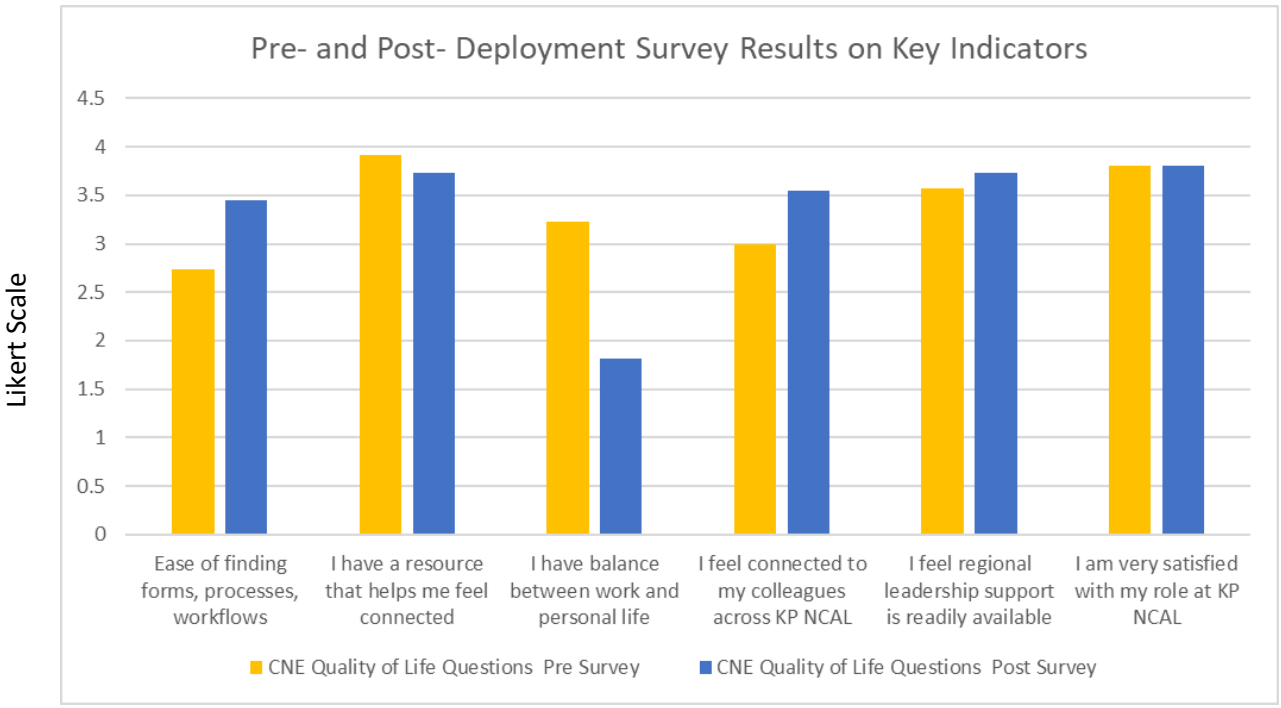
Appendix R

Post Deployment Assessment of Online Resources



Appendix S

Pre- and Post-Deployment Survey Results on Key Indicators



Appendix T

Letter of Support from Agency

University of San Francisco
School of Nursing and Health Professions
2130 Fulton Street
San Francisco, CA 94117

March 8, 2017

To Whom It May Concern:

I am writing to acknowledge support for Patricia “Pidge” Gooch, in completion of her evidence based quality improvement DNP project, Framework of Support and Mentorship for Medical Center Chief Nurse Executives in a Health System, in partial fulfillment of her Doctor of Nursing Practice degree in the Executive Leadership program at the University of San Francisco (USF). As the Chief Nurse Executive and Vice President of Clinical Integration, I will have an opportunity to review any manuscripts that identify Kaiser Permanente submitted for publication prior to submission.

This letter also verifies that Kaiser Permanente has a memorandum of understanding with the School of Nursing and Health Professions at USF for student clinical course work that is supervised by USF faculty.

Sincerely,

Theresa M. Brodrick, RN Ph.D